

**NASSAU DERMATOLOGIC LASER CENTER**

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Patient Name:	What is your reason for your visit today?
Date:	

**Other than the services we have already provided for you, what additional services would you like to learn about? Please check all that apply**

<input type="checkbox"/> Skin care advice <input type="checkbox"/> Skin care products <input type="checkbox"/> Injectable Treatments <input type="checkbox"/> Juvederm/Restalyne <input type="checkbox"/> Facial fine lines/wrinkles <input type="checkbox"/> Thin Lips <input type="checkbox"/> Blotchy skin	<input type="checkbox"/> Chemical Peel <input type="checkbox"/> Facial veins <input type="checkbox"/> Facial redness <input type="checkbox"/> Brown spots/age spots/freckles <input type="checkbox"/> Drooping brow <input type="checkbox"/> Facial fullness/drooping <input type="checkbox"/> Mole removal	<input type="checkbox"/> Scar revision <input type="checkbox"/> Neck wrinkles <input type="checkbox"/> Leg veins <input type="checkbox"/> Unwanted Hair <input type="checkbox"/> Length/Fullness of Eyelashes <input type="checkbox"/> Unwanted Tattoos <input type="checkbox"/> Body Slimming
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**Please answer the following questions on a scale of 1 to 5 by circling the appropriate number.**  
 When looking at my face in the mirror, I believe I look younger, the same as, or older than my true age.

Younger Than	True Age	Older Than
1	2      3	4      5

When looking in the mirror, I am not concerned, somewhat concerned, or very concerned about the appearance of my wrinkles.

Not Concerned	Somewhat Concerned	Very Concerned
1	2      3	4      5

**How did you hear about us?**

<input type="checkbox"/> My physician	Full name:
<input type="checkbox"/> My insurance company provider	Name:
<input type="checkbox"/> The yellow pages	Specify Ad:
<input type="checkbox"/> A friend or family member	Name:
<input type="checkbox"/> Internet	
<input type="checkbox"/> The Physician/Practice website	
<input type="checkbox"/> Seminar	Date/location:
<input type="checkbox"/> Other	

<input type="checkbox"/> Approval to contact you	Best phone number to reach you:
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<input type="checkbox"/> Approval to send you information on products and services	Email address:
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I'm not interested in any additional services provided at this time

**For Staff Use Only**

<b>Physician / provider:</b>		
<i>Follow-up</i>	<i>Date</i>	<i>Completed by:</i>
<input type="checkbox"/> Initial Inquiry/Information Given		
<input type="checkbox"/> Contact in future-give date		
<input type="checkbox"/> Products		
<input type="checkbox"/> Procedure scheduled		
<input type="checkbox"/> Procedure completed		

**Comments**

