THERAPEUTIC LASER CENTER

27400 RIVERVIEW CENTER BLVD. STE. 1

BONITA SPRINGS, FLORIDA 34134

239-301-2319/ FAX: 239-301-0435

Patient Information

Last Name		First Name				MI
Address			City		State	Zip
Home Phone #		Cell Phone #				
Email Address						
Birth Date / /	Age	Sex	M ☐	F ☐	Social Security #	
Single ☐	Married ☐	Widow ☐	Divorced ☐	Employer		

Reason for Visit (Brief Description) :

How Did You Hear About Our Practice?

☐ Referral
Who? ____________________
☐ Internet
☐ Other
What? ____________________

Previous interventions, treatments, or care you've sought for your complaint?

Emergency Contact Information

Name

Phone Number | Relationship

Medical History

Medication	Reason for Taking

Surgery	Reason/ Outcome/ Date

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Past Medical History	Yes	No	Comments/ Notes
Head Aches	☐	☐	
Stroke	☐	☐	
Seizures	☐	☐	
Pneumonia	☐	☐	
Diabetes (Type 1 or Type 2)	☐	☐	
Thyroid Disease	☐	☐	
Glaucoma	☐	☐	
Macular Degeneration	☐	☐	
Hearing Loss	☐	☐	
High Blood Pressure	☐	☐	
Blood Clots	☐	☐	
Heart Burn, Reflux	☐	☐	
Heart Disease	☐	☐	
Stomach Ulcers	☐	☐	
High Cholesterol	☐	☐	
Gastrointestinal Bleeding	☐	☐	
Hepatitis (A, B, C)	☐	☐	
HIV/AIDS	☐	☐	
Chronic Wounds	☐	☐	
Cancer (Type)	☐	☐	
Urinary Tract Infections	☐	☐	
Incontinence	☐	☐	
Kidney Stones	☐	☐	
COPD (Emphysema, Bronchitis)	☐	☐	
Asthma	☐	☐	
Depression	☐	☐	
Bipolar Disorder	☐	☐	
Anxiety	☐	☐	
Fibromyalgia	☐	☐	
Chronic Fatigue Syndrome	☐	☐	
Arthritis	☐	☐	
Gout	☐	☐	
Osteoporosis	☐	☐	
Prostate Disease	☐	☐	
Breast Disease	☐	☐	
Erectile Dysfunction	☐	☐	
Other:			

I have read the above information and certify it to be true and correct to the best of my knowledge and hereby authorize this office to provide me with care, in accordance with this state's statutes

Patient or Guardian Signature ______________________________ Date ____________

Office Use Only:

Height	*Weight*