OREGON
NATURAL MEDICINE
natural health.modern medicine

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Laser Nail Treatment Medical History

Last Name:_____ First Name:_____ M.I.:_____

Gender: ___F ___M DOB:_____/_____/_____ Age: _____

Address:_____City:_____State:_____ Zip:_____

Home Phone:(_____)_____ Cell Phone:(_____)_____

Email Address: _____

Emergency Contact:_____ Phone:_____

How did you hear about our clinic? _____

1. Are you here today for a Nail Fungus problem? ( ) Yes ( ) No
2. How long have you had this problem? _____(Months) (Years)
3. Has this condition been treated before? ( ) Yes ( ) No
4. Check all that you have used or tried:
   Medication:
   ( ) Lamisil Pills: How long? _____ Last time used: _____
   ( ) Pen lac Paint (Ciclopirox): How long? _____ Last time used: _____
   ( ) Diflucan Pills: How long? _____ Last time used: _____
   ( ) Nizoral Pills: How long? _____ Last time used: _____
   ( ) Griseofulvin Pills: How long? _____ Last time used: _____
   ( ) Sporanox Pills: How long? _____ Last time used: _____
   ( ) Anti-fungal Cream or Spray: How long? _____ Last time used: _____
   ( ) Laser Nail Treatment: How long? _____ Last time used: _____
   ( ) Home Treatments (ie Tea Tree): How long? _____ Last time used: _____
   ( ) Other: Type_____ How long? _____ Last time used: _____
5. Do you have any of the following conditions? (Circle all that apply to you) ( ) None

Diabetes	Epilepsy	Heart Disease	High Blood Pressure	Numbness
Neurologic	Stroke	Seizures	Blood disorder	Easy Bleeding
Psoriasis	Skin Cancer	Peripheral Vascular Disease		Scleroderma

   Other:_____
6. Are you currently pregnant? ( ) Yes ( ) No
7. List any medications you are now taking: ( ) None
   _____
   _____
   _____
   _____
8. List any medications you are allergic to: ( ) None
   _____
   _____
   _____
9. Do you get pedicures at Nail Salons? ( ) Yes ( ) No If so, how often? _____
10. Do you have any other foot problems? ( ) Yes ( ) No If so, what are they?
    _____
    _____
    _____

Informed Consent for Laser Treatment

I hereby voluntarily request and willingly consent to receive laser treatment, physical examinations and diagnostic procedures by the Physicians and Healthcare Practitioners at Oregon Natural Medicine, LLC. I understand that the Physicians and Healthcare Practitioners will only be treating me for nail fungus. I understand that I must schedule a separate Naturopathic Medical Appointment for conditions beyond fungal nail treatment.

Appointments:I understand that Oregon Natural Medicine, LLC has **24 hours advance notice cancelation policy**. If you miss your appointment or cancel with less than 24 hours, we will **charge your account $50**. This fee will be waived for emergency situations.

Effectiveness: I understand that laser nail treatment is generally very safe and effective, but I realize that there is no guarantee of cure for my medical condition.

Pregnancy: I understand that laser treatment is contraindicated for pregnant women. I will inform my healthcare practitioner at Oregon Natural Medicine, LLC if I am pregnant, if there is a chance that I may be pregnant, or if I am lactating. Additionally, I understand that certain nutritional and herbal supplements may be harmful to pregnant women and/or their unborn child

Insurance Coverage: I understand that laser nail treatment is considered an Aesthetic procedure and is not covered by health insurance. I understand that my health insurance will not be billed and it is my responsibility to pay at time of service for this procedure.

Privacy Policy: I understand that my medical record will be kept private. I understand that the Clinical and support staff at Oregon Natural Medicine, LLC will have access to my medical record. I acknowledge that my information will never be disclosed to anyone without my consent, except in the case where it is mandated by state law. I understand that I have the right to view my medical chart

Possible Risks and Complications: I am aware that there are risks and possible complications associated with all medical treatment, including the operation or procedure as outlined above. I understand that some of the risks and complications include: discomfort during treatment, usually a "snapping" sensation, crusting or blistering (of skin) immediately following treatment, redness, pain and/or swelling in treated areas immediately following treatment, discoloration of the skin, including lightening or darkening, in the treated area, mild surface scarring or changes in skin texture over the treated areas.

I agree to contact the a staff member of Oregon Natural Medicine, LLC immediately if I believe any adverse reaction may be occurring due to the treatment that was recommended or performed at this clinic. I will inform my healthcare practitioner of any previous allergic reaction I have had to any pharmaceutical, nutritional supplement, herbal supplement, homeopathic supplement or topical medicine.

Consent to be Photographed: I hereby consent to have the treatment site(s) photographed before, during, and/or after treatment, and that these photographs shall be the property of **Oregon Natural Medicine, LLC**, and may be published on our website or displayed in print or electronic media. Identifying information will be concealed.

By signing this form, I agree to the above statements.

Printed name of Patient: _____

Signature of Patient: _____ Date: _____