

Non-Invasive, Non-Surgical, No Down Time Cosmetic Procedures

The California Face & Laser Institute offers a full spectrum on non surgical cosmetic procedures. Our cosmetic surgery center in Palo Alto California offers the latest and most advanced "no down time" procedures to our community.

Phone: (650) 462-3161

Request an appointment online www.calface.com



We bring advanced cosmetic surgeon treatments in areas in addition to those listed above. These include and are not limited to Botox Cosmetic, Thermage, Sun Spot Treatment, Fine Lines Treatment, Wrinkle Treatment, Laser facial peels, Acne Scar Treatment, Excessive Perspiration Treatment, Injectable Fillers Restylane, Laser Hair Removal, Spider Veins, Leg Veins Treatment, Photo Facial, Broken Capillaries on the face, Skin Toning and Pore Refining, Scar Treatment, Facial Redness Treatment, MicroLaserPeel and Microdermabrasion.

Come see us in the San Francisco Bay Area, Palo Alto CA.

Learn more about the California Face & Laser Institute at our web site: www.calface.com

➔ [Body by Thermage™](#)

➔ [BOTOX® Cosmetic](#)

➔ [Comprehensive Facial Treatment Consultation](#)

➔ [Non-Surgical Face, Forehead and Neck Lifting](#)

➔ [Injectable Fillers \(Restylane™\)](#)

➔ [Laser Hair Removal](#)

➔ [Laser Spider and Leg Vein Removal](#)

➔ [Laser Skin Resurfacing](#)

➔ [MicroLaserPeel™ "The Weekend Peel"](#)

➔ [Photorejuvenation \(Photo Facial\)](#)

Directions

From Highway 101 North

Take the University Avenue exit towards Palo Alto and head West on University Avenue. At the second signal, turn right at Woodland. Turn right at the signal into the University Circle complex. Make an immediate left into the first parking lot. The California Face & Laser Institute (CFI) is on the right as you enter the parking lot, and it is located in the California Ear Institute (CEI) Suite 101 on the first floor. There are designated parking spaces for patients.

From Highway 101 South

Take the University Avenue exit towards Palo Alto. Turn left at the signal onto University Avenue. Turn right at the signal onto Woodland. Turn right at the signal into the University Circle complex. Make an immediate left into the first parking lot. The California Face & Laser Institute (CFI) is on the right as you enter the parking lot, and it is located in the California Ear Institute (CEI) Suite 101 on the 1 st floor. There are designated parking spaces for patients.

From Highway 280 North

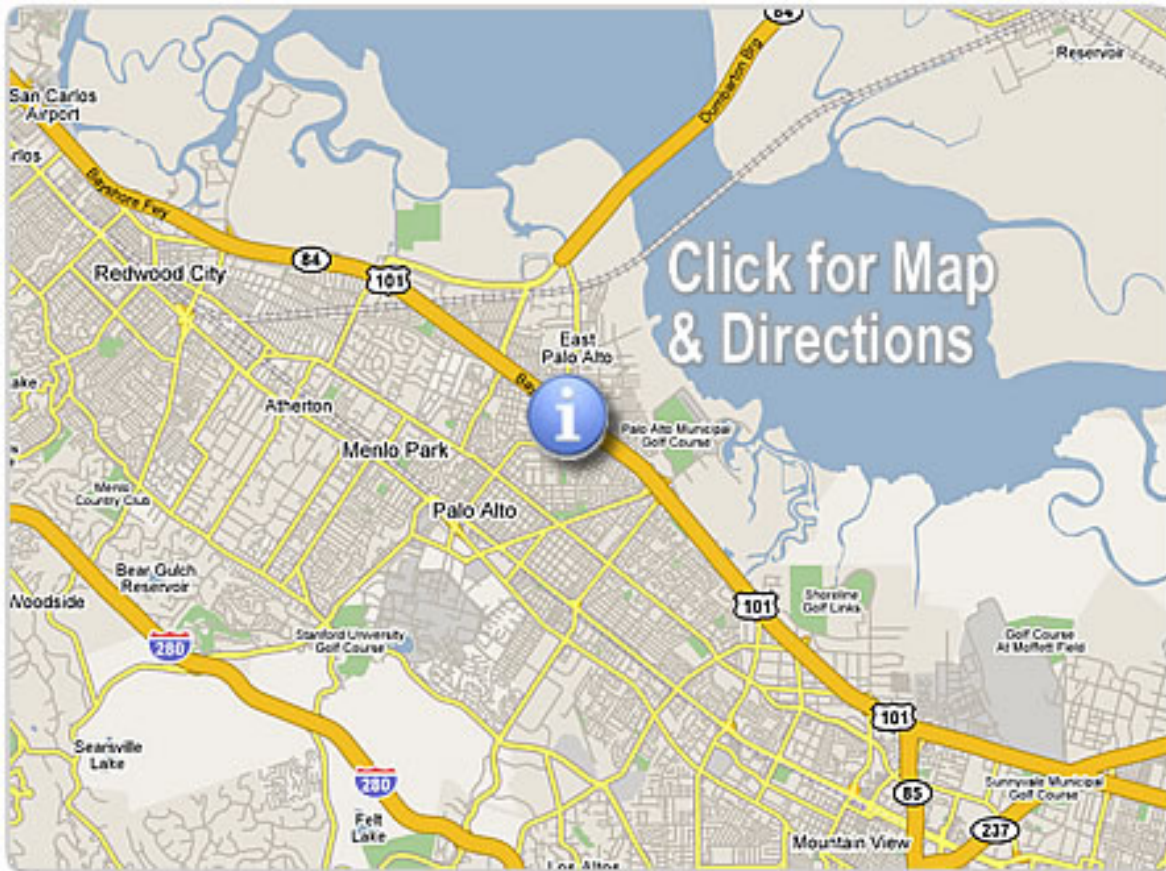
Heading North Take Highway 280 north to Highway 85 north.

Highway 85 north will merge onto Highway 101 north.

Take the University Avenue exit towards Palo Alto and head West on University Avenue. At the 2nd signal light , turn right at Woodland. Turn right at the signal into the University Circle complex. Make an immediate left into the first parking lot. The California Face & Laser Institute (CFI) is on the right as you enter the parking lot, and it is located in the California Ear Institute (CEI) Suite 101 on the first floor. There are designated parking spaces for patients.

From Highway 280 South

Heading South Take Highway 280 to either Highway 380 East or to Highway 92 East, then take Highway 101 South. Take the University Avenue exit towards Palo Alto . Turn left at the signal onto University Avenue. Turn right at the signal onto Woodland. Turn right at the signal into the University Circle complex. Make an immediate left into the first parking lot. The California Face & Laser Institute (CFI) is on the right as you enter the parking lot, and it is located in the California Ear Institute (CEI) Suite 101 on the 1st floor. There are designated parking spaces for patients.



California Face
& Laser Institute

California Face & Laser Institute
1900 University Avenue
Suite 101
E. Palo Alto, CA 94303
Phone: (650) 462-3161

Medical Web Marketing provided by Vital Element, LLC. www.vitalelement.com

Today's Date _____

Patient Information

Name _____ Date of Birth _____ Age _____
last name first name m.i.

Address _____
street apt # city state zip

Mailing Address _____
If different than above city state zip

Home Phone (____) _____ Sex: M F Status: S M D W

Additional Information for PATIENT or Guardian (Required)

Name of responsible person if other than patient or if patient is a minor _____

Relationship to Patient _____ Date of Birth _____

Home Phone (____) _____ Work Phone (____) _____

Cell Phone (____) _____ E-Mail _____

Social Security # _____ Driver's License #/State _____

Place of Birth _____ Occupation _____

Emergency Contact Information

Name of Person to Contact _____

Phone (____) _____ Relationship to Patient _____

Check here to authorize CEI / CSI / CFI / LTHF to disclose your private health information to this individual

Insurance Information

Primary Insurance (Courtesy only for LTHF)

Secondary Insurance (Courtesy only, all Clinics)

Insurance Co. Name _____

Insurance Co. Name _____

Subscriber Name _____

Subscriber Name _____

Subscriber I.D. # _____

Subscriber I.D. # _____

Group or Policy # _____

Group or Policy # _____

Subscriber Date of Birth _____

Subscriber Date of Birth _____

Relationship to Patient _____

Relationship to Patient _____

How Did You Hear About Us?

Reason for Consultation _____

Referred By _____ Specialty _____

Address _____ Phone (____) _____

Or Yellow Pages Relative Friend Employee Event Other _____

Who is your Primary Care Physician? _____

Address _____ Phone (____) _____

Other

I would like to receive information about Let Them Hear Foundation and other CEI related activities e-mail address _____ Yes No

CEI / CSI / CFI / LTHF may leave voice mail messages containing my private health Information on any of the phone numbers listed on this form Yes No

Language I would prefer reminder phone calls in _____



PATIENT INFORMATION FORM

APPOINTMENT DATE: _____

Name: _____
Last First Middle

Date of Birth: _____ Age: _____ Sex: _____

Please check next to the procedures or treatments that you are interested in-

- ___ BOTOX Cosmetic
___ Eyelid surgery
___ Facelift/Necklift/Minilift
___ Endoscopic browlift
___ Cheek lift
___ Skin care
___ Scar revision
___ Facial liposuction
___ MicroLaserPeel/Microdermabrasion
___ Nasal surgery
___ Injectable Fillers (Juvederm/Restylane)
___ Laser hair removal
___ Spider veins / leg vein treatment
___ Photo facial
___ Broken capillaries on the face
___ Skin resurfacing/Active FX
___ Acne scar treatment
___ Chemical peel
___ Ear correction

Other interests not listed: _____

Which of the above have you already had performed? _____

MEDICAL HISTORY

Are you taking any drugs, medications or vitamins? ___ YES ___ NO If yes, list:
1. _____ 2. _____
3. _____ 4. _____

Are you allergic to any medications? ___ YES ___ NO If yes, list:
1. _____ 2. _____

Please list all previous surgeries (including cosmetic) and dates?
1. _____ 2. _____
3. _____ 4. _____

Have you ever received local anesthesia (Novocaine or Xylocaine) by a dentist or doctor?
___ YES ___ NO If bad reaction. describe:

Do you have now, or have ever had diseases or conditions of: (Please check YES or NO)

Table with columns for Lung, Cardiovascular, Gastrointestinal, and Musculoskeletal/neurological conditions, with YES/NO checkboxes.

Hematologic/metabolic:	YES	NO	Other systemic:	YES	NO
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Dry eyes	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding problems	<input type="checkbox"/>	<input type="checkbox"/>	Blurred vision	<input type="checkbox"/>	<input type="checkbox"/>
Blood transfusions	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>
Autoimmune disease	<input type="checkbox"/>	<input type="checkbox"/>	Corrective lenses	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Ear disease	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid disease	<input type="checkbox"/>	<input type="checkbox"/>	Nosebleeds	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	Nasal/sinus disease	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding problems	<input type="checkbox"/>	<input type="checkbox"/>	Other: _____		

List any other diseases or conditions not covered above:

Social History:

Do you drink alcohol? YES NO If YES _____ drinks per week.
 Do you smoke? YES NO If YES, how much: _____
 Have you had or have you been exposed to HIV (AIDS)? YES NO
 (Women) Are you pregnant? YES NO Due Date: _____

Skin: One of the important parameters for the success of your treatment is the correct typing of your skin. Your doctor will consider your skin type when planning your treatment program for many aesthetic medical procedures. Skin type is often categorized according to the Fitzpatrick skin type scale which ranges from very fair (skin type I) to very dark (skin type VI). The two main factors that influence skin type and the treatment program devised by your doctor are genetic disposition and reaction to sun exposure and tanning beds.

Skin type is determined genetically and is one of the many aspects of your overall appearance, which also includes color of eyes, hair, etc. The way your skin reacts to sun exposure is another important factor in correctly assessing your skin type. Recent tanning (sun bathing, artificial tanning or tanning creams) have a major impact on the evaluation of your skin color.

Please take a few minutes and complete this questionnaire to help us determine your skin type and treat you the right way.

GENETIC DISPOSITION:

Score	0	1	2	3	4
What is the color of your eyes?	Light blue, Gray, Green	Blue, Gray or Green	Blue	Dark Brown	Brownish Black
What is the natural color of your hair?	Sandy Red	Blond	Chestnut/Dark Blond	Dark Brown	Black
What is the color of your skin (non-exposed areas)?	Reddish	Very pale	Pale with Beige tint	Light Brown	Dark Brown
Do you have freckles on unexposed areas?	Many	Several	Few	Incidental	None
	< Total score for Genetic Disposition				

REACTION TO SUN EXPOSURE:

Score	0	1	2	3	4
What happens when you stay too long in the sun?	Painful redness, blistering, peeling	Blistering followed by peeling	Burns sometimes followed by peeling	Rarely burns	Never had burns
To what degree do you turn brown?	Hardly or not at all	Light color tan	Reasonable tan	Tan very easy	Turn dark, brown quickly
Do you turn brown within several hours after sun exposure?	Never	Seldom	Sometimes	Often	Always
How does your face react to the sun?	Very sensitive	Sensitive	Normal	Very resistant	Never had a problem
	< Total score for Reaction to Sun Exposure				

TANNING HABITS:

Score	0	1	2	3	4
When did you last expose your body to sun (or artificial sunlamp/tanning cream)?	More than 3 months ago	2-3 months ago	1-2 months ago	Less than a month ago	Less than 2 weeks ago
Did you expose the area to be treated to the sun?	Never	Hardly ever	Sometimes	Often	Always
	< Total score for Tanning Habits				

	< Total score for Genetic Disposition
	< Total score for Reaction to Sun Exposure
	< Total score for Tanning Habits

	< SKIN TYPE SCORE
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FITZPATRICK SKIN TYPE

Skin Type Score	Fitzpatrick Skin Type
0-7	I
8-16	II
17-25	III
25-30	IV
Over 30	V-VI

The above information is strictly confidential

Completed by: Patient

Medical Assistant/RN _____
Initials

Signed by Patient Date

Reviewed by Date