



Name: _____ Date: _____

Address: _____
Street City State Zip

Home Phone: _____ Cell: _____

Date of Birth: _____ Age: _____

Email: _____

*Would you like to be a part of our VIP emailing? YES NO
(Monthly Specials, Events, and Cash Back Rewards)

Emergency Contact: _____ Relationship: _____

Home Phone: _____ Cell: _____

How did you hear about us? _____

Have you had any cosmetic procedures? _____

What treatments are you interested in?

- | | |
|--|---|
| <input type="checkbox"/> Botox | <input type="checkbox"/> Anti-aging Skin Care (Obagi, Vivite) |
| <input type="checkbox"/> Dermal Fillers | <input type="checkbox"/> Latisse |
| <input type="checkbox"/> Laser Skin Rejuvenation | <input type="checkbox"/> Microdermabrasian |
| <input type="checkbox"/> Laser Hair Removal | <input type="checkbox"/> Microcurrent Skin Rejuvenation |
| <input type="checkbox"/> Laser Vein Therapy | <input type="checkbox"/> Jane Iredale Mineral Make-Up |
| <input type="checkbox"/> Chemical Peel | <input type="checkbox"/> Facials or Massages |

Medication (prescription, over the counter, vitamins, herbal supplements)

Allergies: _____

Surgeries/Dates: _____

Do you have a History of?

- | | | |
|--|--|--|
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Mental Disease | <input type="checkbox"/> Neuro-muscular Disease |
| <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Auto-immune Disorders | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Cold Sores/Fever Blisters |
| <input type="checkbox"/> Other | | |

Are you? Pregnant _____ Nursing _____

Do you? Smoke _____ Drink Alcohol _____ Amount per day _____

The above information is true and accurate to the best of my knowledge.

Patient Signature

Date