Skin Deep
Medical Aesthetics

PATIENT DEMOGRAPHICS			
Name:			Date of Birth:
Address:			Home Phone:
City:	State:	Zip:	Cell Phone:
Email:			Occupation:
Emergency Contact:			
Emergency Contact Phone:			
How did you hear about us:			Referral Source Name:

GENERAL HEALTH/HISTORY	YES	NO	NOT SURE
Do you have any metal implants, a pacemaker or body piercings?			
Do you wear contact lenses?			
Do you smoke?			
Are you currently pregnant or breast feeding?			
Do you have an auto-immune disease? (HIV, Lupus, Hepatitis, other)			
Do you have a history of cold sores?			
Do you have a history of genital herpes?			
Do you have a history of heart condition?			
Do you have a history of Diabetes?			
Do you have a history of Blood Clots?			
Have you or are you currently undergoing Chemotherapy or Radiation treatments?			
Have you ever had any facial surgeries?			
Have you ever had laser hair removal?			
Have you recently been tanning or had sun exposure that changed your skin color?			
Have you used any self tanning lotions or treatments?			
Are you currently doing any of the following:			
Electrolysis?			
Tweezing?			
Laser Hair Removal?			
Waxing?			

MEDICATIONS AND ALLERGIES	YES	NO	NOT SURE
Do you have allergies to the following			
Aspirin?			
Latex?			
Hydrocortisone?			
Food? (please list)			
Wheat/Gluten?			
Lidocaine/Novocaine?			
Hydroquinone or skin bleaching agents?			
Any Botulinum toxin (Botox®) product?			
Hypersensitivity to Latisse® (Bimatoprost)?			
Any other allergies? (please list)			

Are you currently using:			
Aspirin?			
NSAIDS? (Motrin, Aleve, Advil)			
Coumadin?			
Birth Control Pills?			
Hormone Replacement?			
Have you ever used Accutane?			
Have you ever used RetinA?			

SKIN CARE			
	YES	NO	WHEN
Have you had any of the following:			
Chemical Peel?			
Microdermabrasion?			
Botox?			
Dermal Fillers?			
Other resurfacing treatments?			
Are you currently using any products that contain:			
Glycolic Acid?			
Lactic Acid?			
Hydroxy Acid?			
Vitamin A?			
Do you have any skin sensitivities or conditions? (please list)			
Do you have Eczema?			
Do you have Psoriasis?			

It is my choice to receive elective cosmetic treatment at Skin Deep Medical Aesthetics. I have completed this form to the best of my knowledge. I have stated all medical conditions that I am aware of and I will update Skin Deep Medical Aesthetics to my health status. I understand that Aestheticians do not diagnose illness, disease, or physical or mental disorders, nor do they prescribe medical treatments,or pharmaceuticals. I acknowledge that these treatments are not a substitute for medical examination or diagnosis, and it is recommended that I see a medical provider at Skin Deep Medical Aesthetics or my regular health care provider for that service.

I understand that treatments received at Skin Deep Medical Aesthetics are to be paid in full up front. If my health insurance does cover any part of my treatment, I understand that Skin Deep Medical Aesthetics is not responsible for billing, my insurance company and that I will need to submit my receipt to my insurance company for reimbursement.

I understand that if I am unable to keep a scheduled appointment that I will need to cancel the appointment 24 hours in advance by phone, unless I have an emergency. In this case I will call ASAP to reschedule my appointment. If I miss an appointment without giving 24 hours notice, I agree to pay the missed appointment fee of $25.00 per appointment.

Signature:_____ Date:_____

Print Name:_____

Witness:_____ Date:_____