

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 foold sores? Do you have a history of float lenbergs? Do you have a history of Polate Interpret Properties of Properties Pr	PATIENT DEMOGRAPHICS						
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Email: Occupation: Emergency Contact: Emergency Contact Phone: How did you hear about us: Referral Source Name: GENERAL HEALTH/HISTORY TYES NO NOT SURE Do you have any metal implants, a pacemaker or body piercings? Do you wear contact lenses? Do you wear contact lenses? Do you wear contact lenses? Do you have an instory of Dear feeding? Do you have an auto-immune disease? (HIV, Lupus, Hepatitis, other) Do you have a history of genital herpes? Do you have a history of open transmine disease? Do you have a history of penital herpes? Do you have a history of penital herpes? Do you have a history of Phear condition? Do you have a history of Phear condition? Do you have a history of Phear condition? Have you cover had any facial surgeries? Have you ever had any facial surgeries? Have you ever had laser hair removal? Have you ever had laser hair removal? Have you ever had laser hair removal? Have you everly been tanning of had sun exposure that changed your skin color? Have you currently doing any of the following: Electrolysis? Tweezing? Laser Hair Removal? Waxing? MEDICATIONS AND ALLERGIES MEDICATIONS AND ALLERGIES MEDICATIONS AND ALLERGIES Po you have allergies to the following Aspirin? Latex? Hydrocortisone? Food? (please list) Wheat (Gluter) Latexe? Hydroquinone or skin bleaching agents? Hydroguinone or skin bleaching agents? Hydroguinone or skin bleaching agents?	Address:				Home Phone	e:	
Emergency Contact: Emergency Contact Phone: How did you hear about us: GENERAL HEALTH/HISTORY Do you have any metal implants, a pacemaker or body piercings? Do you wear contact lenses? Do you wear contact lenses? Do you wear contact lenses? Do you have an auto-immune disease? (HIV, Lupus, Hepatitis, other) Do you have an instory of old sores? Do you have a history of genital herpes? Do you have a history of genital herpes? Do you have a history of penital herpes? Do you have a history of beart condition? 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 ever had laser hair removal? Have you everly doing any of the following: Flectrolysis? Tweezing? Laser Har Removal? Making? MEDICATIONS AND ALLERGIES MEDICATIONS AND ALLERGIES MEDICATIONS AND ALLERGIES MEDICATIONS ON DIALERGIES MEDICATIONS ON	City:	State:	Zip:		Cell Phone:		
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Hypersensitivity to Latisse® (Bimatoprost)?	Hydroquinone or skin bleaching agents?						
	. / 2						
Any other allergies? (please list)	, , ,						
	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?							
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.							
company and that I will need to such any receipt to my insurance company for remoundances.							
I understand that if I am unable to keep a scheduled appointment that I will need to cancel the app	pointment 24 h	ours in advanc	e				
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:						