Skin Deep
Medical Aesthetics

Patient Demographics

Kara Flaherty, MD
ph: (802) 879-3742 ● fax: (802) 878-6131

Name: _____ **DOB:** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Phone: _____ **Email:** _____

Emergency Contact: _____ **Emergency Contact Phone:** _____

How did you hear about us? _____

Allergies	Yes	No	Unsure
Aspirin			
Latex			
Hydrocortisone			
Food (please list)			
Wheat/gluten			
Lidocaine/Novocaine			
Hydroquinone or skin bleaching agents			
Any botulinum toxin (Botox) products			
Hypersensitivity to Latisse (Bimatoprost)			
Other			

General History	Yes	No	Unsure
Pacemaker			
Do you wear contact lenses?			
Do you smoke?			
Are you currently pregnant or breastfeeding?			
Do you have an autoimmune disease? (HIV, Lupus, Hepatitis, etc.)			
History of cold sores?			
History of genital herpes?			
History of Diabetes Mellitus?			
History of blood clots?			
Have you or are you currently undergoing chemotherapy/radiation?			
History of facial surgeries?			
History of laser hair removal?			
Have you recently been tanning?			
Have you had sun exposure that changed your skin tone?			
Have you used any self-tanning lotions or treatments?			

Are you currently doing any of the following?	Yes	No	Unsure
Electrolysis			
Tweezing			
Laser hair removal			
Waxing			

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Are you currently taking any of the following?	Yes	No	Unsure
Aspirin			
NSAIDS (Motrin, Aleve, Advil)			
Coumadin			
Birth control pills			
Hormone replacements			
Have you ever used Accutane?			
Have you ever used RetinA?			

Have you had any of the following procedures?	Yes	No	Unsure
Chemical peel			
Microdermabrasion			
Botox			
Dermal fillers			
Resurfacing treatments			

Are you currently using any products that contain the following?	Yes	No	Unsure
Glycolic acid			
Hydroxy acid			
Vitamin A			

Have you had any skin sensitivities or conditions?	Yes	No	Unsure
Eczema			
Psoriasis			
Other			

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 changes. I understand that aestheticians do not diagnose illness, disease, 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. I understand 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 and that I will need to submit my receipt to my insurance company for any reimbursements.

I understand that if I am unable to keep a scheduled appointment that I will need to cancel the appointment 24 hours in advance. If I miss an appointment or cancel without a 24 hour notice, I agree to pay the missed appointment fee of $100.00 per appointment.

Printed Name: _____

Signature: _____ **Date:** _____