Aesthetic Skin Care Center

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Patient Information

First Name:______________________________ Last Name:__________________________________

Address:____

City:___________________________ State:____________ Zip:__________________________

Date of Birth:_________/_____/______

Home Phone: ____________________________ Cell phone:_________________________________

Work Phone: ____________________________ Other: ______________________________

May we contact you/ leave messages at any of these?_______________________________

Email:____

Permission to communicate via e-mail? •YES •NO

How did you hear about our practice/ who referred you?____________________________

Health Questions

Please circle the appropriate answer if you have experienced any of the following in your current and/or past medical history.

Prolonged bleeding when cut	•YES	•NO	Shortness of Breath	•YES	•NO
Diabetes	•YES	•NO	Fainting or Blackout Spells	•YES	•NO
High Blood Pressure	•YES	•NO	Joint problems and/or pain	•YES	•NO
Heart Trouble/ Disease	•YES	•NO	Visual Problems	•YES	•NO
Irregular Pulse	•YES	•NO	Excessive Scarring	•YES	•NO
Cancer	•YES	•NO	Autoimmune Disorder	•YES	•NO
Hepatitis	•YES	•NO	Other:______________________		

Allergies:____

Height:___________________________ **Weight:**_______________________________

*Please note there will be a $100 fee assessed for consultations, however, the fee may be waived if the procedure is being preformed same day. All fees are collected on the day of service. If you have any questions, please do not hesitate to ask.

Signature:_____________________________________ **Date:**_________/_____/______