

Last Name: _____ First Name: _____ Sex: _____
Address: _____
City: _____ State: _____ Zip Code: _____ Date of Birth: _____
Telephone Home: _____ Work: _____ Cell: _____
Emergency Contact: _____ Phone: _____ Relation: _____
Occupation: _____ Employer: _____ Marital Status: _____

Email (to receive newsletter/promotions): _____

How did you hear about us?

Friend (their name will allow us to thank them) _____ Google _____ Botox website _____
Other: _____

Please answer all of the following questions:

- | | | |
|--|-----|----|
| 1. Do you have ANY current or chronic medical illness? | Yes | No |
| Please list: _____ | | |
| 2. Do you take ANY medications, vitamins, supplements, topical treatments? | Yes | No |
| Please list: _____ | | |
| 3. Do you have ANY allergies to medications, foods, latex, or other substances? | Yes | No |
| Please list: _____ | | |
| 4. Do you have a history of cold sores/ herpes I or II in the area being treated? | Yes | No |
| 5. Do you have a history of keloid scarring? | Yes | No |
| 6. Have you had unprotected sun exposure, used tanning creams or beds in the last 4-6 weeks? | Yes | No |
| 7. Do you have permanent make up or tattoos? | Yes | No |
| Please list location: _____ | | |

For women 8 & 9:

- | | | |
|--|-----|----|
| 8. Are you or could you be pregnant? | Yes | No |
| 9. Are your menstrual periods regular? | Yes | No |

10. Skin type:

- | | | |
|-----|----------------|-------------------------------------|
| I | White | Always burns, never tans |
| II | White | Usually burns, tans with difficulty |
| III | White/Asian | Sometimes burns, average tans |
| IV | Moderate Brown | Rarely burns, tans with ease |
| V | Dark Brown | Very rarely burns, tans very easily |
| VI | Black | Never burns |

11. Color of hair you want removed: _____ Have you bleached the hair you want removed? Yes No
If so when did you last do so? _____ Laser hair removal is NOT effective on white/gray or light/medium blonde hair.

12. Please list any prior cosmetic procedures you've had: _____

(over, please)

I understand that my insurance does not cover cosmetic procedures and that payment is due in full today.

I consent to the taking of photographs and authorize their anonymous use for the purpose of medical audit, education and promotion.

Signature: _____ Date: _____

Patient Agreement of Financial Responsibility:

My physician has notified me that my health insurance carrier may not cover acupuncture and cosmetic treatments. I agree to be personally and fully responsible for payment of these services which are due at the time of service. There are no refunds given on services already rendered.

Cancellation Policy:

This office has a policy of charging a fee for missing and appointment or cancelling with less than a working day's notice. This policy is explained to me at the first visit. The fee is \$50.

The purpose of the fee is to encourage our patients to take their appointments as seriously as we do. That time is reserved for you, and if you do not keep the schedule other patients who need 'same day' visits, or earlier appointments than the schedule permits are being obliged to wait longer than necessary.

We remain available to discuss this policy in general or individual circumstances. We thank you for your understanding.

There will be a \$30.00 charge for any returned check.

Print Name

Signature

Date