

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Sex: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Telephone Home: \_\_\_\_\_ Work: \_\_\_\_\_ Cell: \_\_\_\_\_  
Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_ Marital Status: \_\_\_\_\_  
Which of your numbers may we leave a detailed message at? Please circle: work, home, cell, none

Email (to receive newsletter/promotions once a month): \_\_\_\_\_  
Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_ Relation: \_\_\_\_\_

Whom may we thank for this referral? \_\_\_\_\_

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, If yes 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. Circle Your 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. For Laser Hair Removal color of hair you want removed: \_\_\_\_\_ Have you bleached the hair you want removed?  
If so when did you last do so? \_\_\_\_\_ Laser hair removal is NOT effective on white/gray or light blonde hair.

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

What treatments are you interested in learning more about?

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Hair Restoration/Surgery                              | <input type="checkbox"/> Medical Weight Loss     | <input type="checkbox"/> Hand, Neck, Chest Rejuvenation |
| <input type="checkbox"/> Improving Acne  | <input type="checkbox"/> Reducing wrinkles       | <input type="checkbox"/> Reducing Brown Spots           |
| <input type="checkbox"/> Reducing Spider Veins                                 | <input type="checkbox"/> Vitamin Injections      | <input type="checkbox"/> Removing Skin tags/moles/warts |
| <input type="checkbox"/> G Shot  | <input type="checkbox"/> Reducing Cellulite      | <input type="checkbox"/> Medical Grade Chemical Peels   |
| <input type="checkbox"/> Non surgical lip, nose, cheek, chin, ear Augmentation | <input type="checkbox"/> Improving skin textures |   |
| <input type="checkbox"/> Men's Vitality/testosterone replacement               |  |   |

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: \_\_\_\_\_ (over, please)

Ava Integrative Med Spa  
760-757-7864

**Patient Agreement of Financial Responsibility:**

My physician has notified me that my health insurance carrier may not cover provided treatments. I agree to be personally and fully responsible for payment of these services which are due at the time of service.

**Cancellation Policy:**

This office has a policy of charging a fee for failing to show up within 15 minutes of scheduled appointment time or cancelling with less than 24 BUSINESS hours notice (calls after 5 pm and on weekends/holidays are NOT considered business hours). 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.

\_\_\_\_\_

Print Name

\_\_\_\_\_

Signature

\_\_\_\_\_

Date