COSMETIC LASER AND AESTHETICS CENTER

PERSONAL INFORMATION

Please complete the following: Date: ________________________

Name: ____ Date of Birth:___________________

Home Address: ____

City: ______________________________ State: _________________ Zip: _____________

Home Telephone: (____) ___________________ Cell: (____) _________________________

Work Phone: (_____)___________________ Email _____________________________________

This gives us permission to contact you regarding products, treatments, and promotions at all of the above methods: If not, indicate which ones we may use:__________________

How did you hear about us? ____

If through internet search, please tell us what source or words you searched:
____

MEDICAL HISTORY

Please list all allergies (including medications, food, poultry, latex, cosmetics, lidocaine, etc.)
____
____

Please list all medications, including herbal (esp. St John's Wort) or over the counter, you take on a regular basis, or have taken in the last six months:
____
____
____
____

List all operations (including plastic/laser procedures), hospitalizations, and any serious illnesses:
____
____
____

What are your concerns (please circle any of the following):
Unwanted hair, brown/red spots, wrinkles, lines, sagging skin, acne, blemishes, large pores, age spots, spider veins, other (please list):____
____
____

	Yes	No	Dates
Insulin dependent diabetes	___	___	___________
High Blood Pressure	___	___	___________
Frequent Headaches	___	___	___________
Seizure or epilepsy disorder	___	___	___________
Active skin disease/lesions	___	___	___________
Active infection, Staph infection	___	___	___________
Cancer	___	___	___________
Blood clots	___	___	___________
Stroke	___	___	___________
Serious cardiac disease	___	___	___________
Bleeding problems with cuts, surgery	___	___	___________
Jaundice or Hepatitis	___	___	___________
Thyroid Disease	___	___	___________
Dizziness, palpitations, fainting spells	___	___	___________
Cold sores, mouth blisters, fever blisters	___	___	___________
Weight change of 10 lbs in last 6 mo.	___	___	___________
Psychiatric Disorders	___	___	___________
Arthritis	___	___	___________
Hormone imbalance	___	___	___________
Herpes	___	___	___________
HIV/Aids	___	___	___________
Keloids/scars	___	___	___________
Skin cancer/melanoma	___	___	___________
Vitiligo, scleroderma, lupus, hives	___	___	___________
Tattoos or permanent makeup	___	___	___________
Other	___	___	___________

Please elaborate on any yes answers____

____

____

SKIN HISTORY

Which of the following best describes your skin type? (please circle one skin type number)

I	Always burns, never tans
II	Always burns, sometimes tans
III	Sometimes burns, always tans
IV	Rarely burns, always tans
V	Brown, moderately pigmented skin (Hispanic)
VI	Black skin

Do you have a history of livido reticularis, an autoimmune disease, in which the blood vessels are constricted or narrowed resulting in mottled discoloration on large areas of the leg or arms? Yes No

Do you have a history of erythema ab igne, which is a persistent skin rash produced by prolonged or repeated exposure to moderately intense heat or infrared irradiation? Yes No

Have you ever used Accutane? Yes No

If yes, when did you last use it?_______________

What topical medications or creams are you currently using? RetinA [ ] others (please list):

____

Have you ever had laser hair removal? Yes No

Have you used any of the following hair removal methods in the past six weeks? shaving [ ] waxing [ ] electrolysis [ ] plucking [ ] tweezing [ ] stringing [ ] depilatories [ ]

Have you had any recent tanning or sun exposure that changed

the color of your skin? Yes No

Have you recently used any self-tanning lotions or treatments? Yes No

Do you form thick or raised scars from cuts or burns? Yes No

Do you have hyperpigmentation (darkening of the skin) or hypopigmentation (lightening of the skin) or marks after physical trauma? Yes No

If yes please describe:____

Notify your physician (circle drug) if you have used any of the of the following in the last year (as they are a contraindication to some laser procedures): St. John's wort, accutane, tetracycline.

Circle any of the following medications you have taken in the last 6 months (as they may increase hair growth):

Birth control pills, androgens (rogaine), penicillin, cyclosporins, minoxidil, steroids, haldol, phenytoin, thyroid medications.

For our Female clients: Are you pregnant or trying to become pregnant? Yes No

Are you using contraception? Yes No

Are you breastfeeding? Yes No

Have you ever smoked? Yes No How much? __________ How long? __________

Are you still smoking? Yes No When did you quit? ______________________

Who is your personal physician:____

Who is your personal dermatologist:____

SKIN CARE & WAXING INFORMATION

List any special skin conditions pertaining to your face or body:___________________________
____

What skin care products are you currently using?
Face: __soap, __cleanser, __toner, __moisturizer, __masks, __exfoliator, __eye products, __self tanner
Body: __soap, __shower gel, __scrubs, __oil, __moisturizer, __depilatory products, __self tanner

Have you ever had __chemical peels, __microdermabrasion, __or any resurfacing treatments?
In the last three months? __yes __no
Do you use __Accutane, __Retin-A, __Renova, __Adapalene or any other prescription skin products? __yes __no In the last three months? __yes __no
Are you currently using any products that contain the following ingredients:
__glycolic acid __lactic acid __exfoliating scrubs __hydroxy acid __vitamin A (retinol)
Do you ever experience these conditions on your skin: __flakiness __tightness __obvious dryness
Do you have a tendency to redness? __yes __no
Do you ever experience oily shine during the day? __yes __no
Do you ever experience skin breakouts? __yes __no
Do you ever experience a burning, itching sensation on your skin? __yes __no
Have you ever had a reaction to any of the following: __cosmetics __medicine __iodine __pollen __food __hydroxy acids __animals __fragrance __sunscreens __others______________________

What are your skin care goals?____
____

I certify that the preceding history statements are true and correct. I am aware that it is my responsibility to inform my service provider of my current medical or health conditions. It is my responsibility to inform my service provider of any changes to preceding information. If I am to enjoy alcohol as part of my experience, I will not hold Skin responsible for any effects/problems that may occur resulting from alcohol consumption after I leave the spa.

Signature: _____________________________ Date: ________

RN/MA Signature: _____________________________ Date: ________

Physician Signature: _____________________________ Date: ________

PLEASE SEE NEXT TWO PAGES

Please read and sign the list of services, prices and the <u>payment and cancellation policy</u> on the following two pages.

Client Agreement - Payment and Cancellation Policy

(Prices do not include <u>required skincare</u> before & after procedures)

- ***Fractional CO2 Laser Facial Resurfacing***
  Active FX, Deep FX, Total FX
  Face $2500, Face/Neck $3000, Face/Neck/Chest $3500
  (pricing does not include required skincare before & after procedure)

- ***Fraxel Re:store Dual***
  Face $1500, Face/Neck $1800, Face/Neck/Chest $2100, Face/Neck/Chest/Hands $2400
  (pricing does not include required skincare before & after procedure)

- ***Lam Probe***
  $100 minimum treatment
  (pricing by doctor consultation)

- ***IPL for Photo Rejuvenation***

Per Treatment	
Face	$400
Face & Neck	$500
Face, Neck & Chest	$700
Hands	$300
Other areas	inquire for pricing

- ***Lightsheer™ Laser Hair Removal***

Per Treatment		per treatment	
Upper Lip	$150	Bikini Line	$195
Chin	$150	Extensive Bikini	$275
Lip & Chin	$195	Lower Legs	$275
Cheeks	$195	Complete Legs	$395
Full Woman's Face	$250	Sideburns	$150
Naval Line	$150	Man's Face	$295
Underarms	$195	Man's Back	$325
Hands/Feet	$195	Chest/Abdomen	$325
Lower Arm	$195	Neck (Front)	$195
Full Arm	$295	Neck (Back)	$195

- ***Laser Spider Vein Treatment***
  $300 for the first 15 minutes, $100 per additional 15 minutes
- ***Clear + Brilliant Laser Treatment***
  Face $300, Face & Neck $400, Face/Neck/Chest $500
  (pricing does not include required skincare after procedure)

- ***Injections***
  $25 Botox Service Fee with Each Treatment

Botox	$12 per unit (average area requires 10-20 units)
Juvederm	1 syringe $600, 2 syringes $1000, 3 syringes $1500, 4 syringes $2000
Lipo	6 shots for $200 or 12 shots or $360

- ***Aesthetic Facial Treatments***

<u>Illuminize Peels</u>	$100
<u>Vitalize Peel</u>	$150
<u>Rejuvenize Peel</u>	$250
<u>HydraFacial</u>	$160
<u>HydraFacial (Face, Neck & Chest)</u>	$195

Appointment Cancellation Policy

When scheduling your appointment we will obtain your credit card to hold your appointment.
To ensure that your services start on time, we request that you arrive at least 15 minutes prior to your scheduled service. If you are a new patient, please arrive 30 minutes prior to your consultation. If you are late, it will cut into your service time or could cause your appointment to be cancelled. If this occurs our cancellation policy will take effect. Please call us if you are going to be late.
Cancellation Policy if you need to cancel your appointment:

CO2 Laser Resurfacing & Fraxel appointments must be cancelled 48 hours minimum before procedure date. If not, you will be charged a cancellation fee of $500.
IPL, Hair Removal, Exilis, Clear + Brilliant laser, & Spider Vein Removal appointment must be cancelled 24 hours before procedure date. If not, you will be charged a cancellation fee of $100.
Botox or Juvederm appointment must be cancelled 24 hours before procedure date. If not, you will be charged a cancellation fee of $100.
HydraFacials & Chemical Peels must be cancelled 24 hours before service date. If not, you will be charged for entire service cost. Clients with multiple appointments scheduled within one day must give 48 hours notice of cancellation. .

Policy Against Treatment Elsewhere

Here at Skin, we are happy to treat any and all of your concerns with the treatments and skincare we have to offer. It is important for you to understand that during your treatment at Skin we will give you a comprehensive plan to best suit your needs and therefore it is important that you do not use skincare or undergo treatments at another facility or practice. This will ensure that your treatments are only done with the supervision of Dr. and his highly trained staff and not at another facility that may cause problems with the skincare and treatments that you receive here. This is not in any way to keep you from getting a second opinion if you so choose, but Skin reserves the right to discontinue the patient relationship if you do so without Dr. 's approval. Dr. will be happy to recommend and refer you to specialists in other fields if needed, but he requests that you ask him for a referral. As your physician, Dr. is responsible for your complete care and we appreciate your consideration and compliance with this policy which will ultimately ensure that you receive the best and most comprehensive treatment plan.

I have read, understand, and agree to comply with all of the above policies with regards to my financial obligations. I understand that I am responsible for payment in full of all fees as quoted above. Fees are non-negotiable outside of approved specials and discounts. **Please have your credit card ready so we can scan it to your file.**

____

Patient Signature