DERMACENTER
MEDICAL SPA
medical spa | skin care services

CLIENT INFORMATION AND MEDICAL HISTORY

PERSONAL INFORMATION

NAME: _____ TODAY'S DATE: _____

DATE OF BIRTH: _____ AGE: _____ OCCUPATION: _____

HOME ADDRESS: _____ CITY: _____ STATE: _____ ZIP CODE: _____

PHONE #: _____ EMAIL: _____

EMERGENCY CONTACT NAME AND PHONE: _____

HOW WERE YOUR REFERRED TO US? _____

WHAT TREATMENTS ARE YOU INTERESTED IN? *Please check those that apply*

- ☐ Laser Hair Removal
- ☐ Skin Rejuvenation
- ☐ Cellulite Reduction
- ☐ Medical Grade Products
- ☐ Vein Removal
- ☐ Skin Tightening
- ☐ Chemical Peel
- ☐ Microdermabrasion
- ☐ Juvéderm/Fillers
- ☐ Skin Analysis
- ☐ BOTOX® Cosmetic

WHICH OF THE FOLLOWING BEST DESCRIBES YOUR SKIN TYPE? *Please check the appropriate box or boxes*

- ☐ Always burns, never tans (1)
- ☐ Always burns, sometimes tans (2)
- ☐ Sometimes burns, always tans (3)
- ☐ Rarely burns, always tans (4)
- ☐ Brown skin (5)
- ☐ Black skin (6)

HAVE YOU EVER HAD LASER HAIR REMOVAL? ☐ Yes ☐ No

HAVE YOU USED ANY OF THE FOLLOWING HAIR REMOVAL METHODS IN THE PAST SIX WEEKS? *Please check those that apply*

☐ Shaving ☐ Waxing ☐ Electrolysis ☐ Plucking/Tweezing ☐ Stringing ☐ Depilatories

HAVE YOU HAD A DEEP CHEMICAL PEEL IN THE LAST THREE MONTHS? ☐ Yes ☐ No

HAVE YOU HAD ANY RECENT TANNING/SUN EXPOSURE THAT CHANGED YOUR SKIN COLOR? ☐ Yes ☐ No

HAVE YOU RECENTLY USED ANY SELF-TANNING LOTIONS OR TREATMENTS? ☐ Yes ☐ No

ARE YOU CURRENTLY USING ANY MEDICAL-GRADE SKIN-CARE PRODUCTS? ☐ Yes ☐ No
IF YES, PLEASE LIST: _____

DO YOU FORM THICK OR RAISED SCARS FROM CUTS OR BURNS? ☐ Yes ☐ No

DO YOU HAVE HYPER- OR HYPO-PIGMENTATION (DARKENING OR LIGHTENING OF THE SKIN) OR MARKS AFTER PHYSICAL TRAUMA?
☐ Yes ☐ No
IF YES, PLEASE DESCRIBE: _____

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MEDICAL HISTORY

ARE YOU PREGNANT OR NURSING? ☐ Yes ☐ No

HAVE YOU EVER HAD AN ALLERGIC REACTION TO ANY OF THE FOLLOWING? *Please check all that apply*

☐ Food ☐ Latex ☐ Aspirin ☐ Lidocaine ☐ Hydrocortisone
☐ Hydroquinone or skin bleaching agents ☐ Other: _____

DESCRIPTION OF REACTION (IF ANY): _____

DO YOU CURRENTLY HAVE, OR HAVE YOU EVER HAD, ANY OF THESE MEDICAL CONDITIONS? *Please check all that apply*

☐ Tattoo or permanent makeup ☐ Impaired immune system ☐ Cancer
☐ Pacemaker/defibrillator ☐ Frequent cold sores ☐ Hepatitis
☐ Blood clotting abnormalities ☐ Keloid scarring ☐ Arthritis
☐ Hormone Imbalance ☐ Thyroid imbalance ☐ Any active skin infection or herpes
☐ Facial laser resurfacing ☐ Cardiac disorders ☐ Endocrine disorders (i.e. diabetes, PCO
☐ High Blood Pressure ☐ Varicose veins
☐ Hepatitis ☐ Dermal Fillers such as Juvéderm or Restylane
☐ HIV/AIDS ☐ Skin disease/skin Lesions (i.e. psoriasis, eczema, sores, rashes)
☐ Metal implant(s) ☐ Light-stimulated disease (i.e. lupus, epilepsy, porphyria)

DO YOU HAVE ANY OTHER HEALTH PROBLEMS OR MEDICAL CONDITIONS? IF SO, PLEASE LIST: _____

_____

_____

WHAT ORAL MEDICATIONS ARE YOU PRESENTLY TAKING?

☐ Birth control pills ☐ Hormones ☐ Antibiotics ☐ Others (Please list): _____

ARE YOU ON ANY MOOD ALTERING OR ANTI-DEPRESSION MEDICATION? ☐ Yes ☐ No

IF YES PLEASE LIST: _____

HAVE YOU EVER USED ACCUTANE OR OTHER MEDICATIONS OR HERBS INDUCING PHOTOSENSITIVITY? ☐ Yes ☐ No

IF YES, WHAT WAS THE PRODUCT AND WHEN DID YOU USE IT? _____

WHAT TOPICAL MEDICATIONS, CREAMS OR HERBS ARE YOU CURRENTLY USING?

☐ RetinA ☐ Others (Please List): _____

I certify that the preceding medical, personal and skin history statements are true and accurate. I am aware that it is my responsibility to inform the technician, esthetician, therapist, doctor or nurse of my current medial or health conditions and to update this history. A current medical history is essential for the caregiver to execute appropriate treatment procedures.

Client/Guardian Signature: _____ Date: _____

Reviewed By: _____ Date: _____

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CANCELLATION POLICY

We ask that you please give us one business day's notice before cancelling your appointment. If you do not call us to cancel your appointment, you will be charged a $25 service fee for appointments 45 minute or less and $50 for sixty minutes (or longer) appointment.

Please be assured that all card numbers are kept in a secure password protected system. By signing below, you acknowledge that you understand our cancellation policy and we reserve the right to charge your credit card the service fee. Please keep your credit card information updated.

By signing below you acknowledge that you have had the opportunity to ask questions regarding this payment and cancellation policy and have had the opportunity to decline participation with this office.

Print full name as appears on credit card	Signature	Date

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PATIENT CONSENT

PATIENT NAME _____

I authorize **DERMACENTER** to perform the following cosmetic procedure: chemical peel, microdermabrasion, laser hair removal, IPL(skin rejuvenation), skin tightening, spider vein reduction, micro needling or sublative rejuvenation.

I understand that clinical results may vary depending on individual factors, including medical history, skin type, patient compliance with pre/post treatment instructions, and individual response to treatment.

I understand that there is a possibility of short-term effects such as reddening, burning, temporary bruising and temporary discoloration of the skin, scab formation, swelling as well as the possibility of rare side effects such as burn, scarring and permanent discoloration including hyper or hypopigmentation. These effects have been fully explained to me _____ **(Patient's initials).**

I understand that for best results, the treatment I am receiving involves a series of treatments and the fee structure has been fully explained to me. I understand that packages are not refundable. _____**(Patient's initials)**

I certify that I have been fully informed of the nature, purpose, expected outcomes and possible complications of the procedure, and I understand that no guarantee can be given as to the final result obtained. I am fully aware that my condition is of cosmetic concern and that the decision to proceed is based solely on my expressed desire to do so.

I confirm that I have informed the staff regarding any current or past medical conditions, diseases or medications taken.
I acknowledge that if I am prone to Herpes (cold sores, fever blisters) that I may need a prescription for an anti-viral medication (acyclovir) from my physician prior to treatment.
I acknowledge that I should avoid use of Glycolic Acid or Retin A type products for 1 week or more if I am receiving a medical laser or facial treatment. I acknowledge that I have not used Accutane (isotrentinoin) during the last six months.
I consent to the taking of photographs for before and after pictures. _____**(Patient's initials)**

I certify that I have been given the opportunity to ask questions and that I have read and fully understand the contents of this consent form.

PATIENT SIGNATURE _____ Date _____

WITNESS SIGNATURE_____ Date_____

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