Date: _____

Personal History

Name:_____ Age_____ Date of Birth:_____Gender: F M

Address:_____
Street City State Zip Code

Home Phone:_____Work Phone:_____

Cell Phone:_____At which numbers is it ok to leave a message?_____

Email Address:_____Occupation:_____

Emergency Contact:_____Relationship:_____ Phone:_____

How did you hear about our clinic?_____

Have you had any previous cosmetic procedures? If yes, please check the appropriate box.

□ Facials/Peels	□ Waxing	□ Juvederm	□ Other Filler	□Microderm Abrasion
□ Photofacials	□ Botox	□ Restylane	□ Micro-needling	□ Laser Hair Removal
□ Laser Vein	□ Dysport	□ Radiesse	□ CO2 Laser Resurfacing	□ Plastic Surgery

Other:_____

Please list all products you are using in your daily skincare routine (face wash, moisturizer, prescription topicals etc.)

_____

_____

_____

My skin type is:

□ Normal □ Oily □ Dry/Dehydrated □ Combination □ Acne/Acne prone □Rosacea

Have you used Accutane (isotretinoin) in the past?_____If so, when?_____

Do you currently have or have a history of any of the following conditions?

Cancer	Yes	No	Melasma	Yes	No	Pacemaker	Yes	No
Diabetes	Yes	No	Psoriasis	Yes	No	Metal Implants	Yes	No
Rosacea	Yes	No	Eczema	Yes	No	Skin rash/disease	Yes	No
Bells Palsy	Yes	No	Keloid scaring	Yes	No	Bleeding Disorder	Yes	No
Anemia	Yes	No	Migraines	Yes	No	Herpes/Cold Sores	Yes	No
Acne	Yes	No	Liver Disease	Yes	No	Severe Allergies	Yes	No
HIV/AIDs	Yes	No	Very dry skin	Yes	No	Mental Disorder(s)	Yes	No
Hepatitis C	Yes	No	Seizures	Yes	No	Autoimmune Disease	Yes	No

Neuromuscular Disorder Yes No Recent Dental Procedure Yes No (within 4 weeks)

Currently pregnant/nursing Yes No

Other Current Medical Conditions:_____

Current Prescriptions, Over-the-counter Medications & Supplements (name, dose):_____

_____

_____

Drug Allergies:_____

Allergies/Sensitivities (food, seasonal):_____

_____

Latex Allergy: Yes No Novocaine or Lidocaine Allergy: Yes No

History of anaphylactic reaction(s): Yes No If yes, to what? _____

Photo Acknowledgment

I understand that my pictures are taken before and after my procedures as a routine part of the services I receive at Elemental Aesthetics. I acknowledge that the pictures taken are for the purposes of my confidential medical file only, and will NOT be used for any purposes other than for providing me the best possible patient care. I understand that only I can request any copies of these pictures that may be released from Elemental Aesthetics, and that to do so my request must be provided in writing. By initialing, I acknowledge this policy & agree to my photos to be taken for my file. _____ **(initial)**

Monthly Newsletter

_____ (initial) **Please sign me up for the email list**. By initialing, I acknowledge that I am requesting to receive the monthly newsletter with monthly updates & featured services. I will also **receive $25 off** my first treatment by signing up for the newsletter (***minimum purchase of $200 required***). By *not* initialing, I will not receive the monthly email or $25 off my first treatment. *(optional)*

Patient Agreement

At Elemental Aesthetics we strive to provide the best treatments and highest quality of professional service in an on-time manner. If you are unable to keep the appointment that you scheduled, we ask that you respectfully reschedule or cancel the appointment within 24 hours. We realize that your time is valuable and hope you will extend the same courtesy to our physicians. A treatment minimum of $200 is required to qualify for monthly newsletter and referral credit. We do confirm scheduled appointments by email, text messaging or phone. Please specify how you would prefer we contact you regarding your appointments:

□ Phone □ Email □ Text Message

I understand the above policy and agree to comply. By signing, I attest that all the above patient information is true and accurate to the best of my ability.

Name:_____ Date:_____

Signature:_____

Practitioner:_____ Date:_____

Name:_____ Date:_____ Date of Birth:_____

What are your areas of concern? Please check all that apply.

- ☐ Facial Wrinkles
- ☐ Red Spots
- ☐ Pore Size
- ☐ Lips
- ☐ Melasma
- ☐ Sun Damage
- ☐ Active Acne
- ☐ Acne Scaring
- ☐ Nose
- ☐ Excess Fat
- ☐ Crepey Skin
- ☐ Weight
- ☐ Low energy
- ☐ Under Eyes
- ☐ Facial Aging
- ☐ Saggy Skin
  - ☐ Face
  - ☐ Eyes
  - ☐ Jowels
- ☐ Hands (tendons, veins)
- ☐ Hair Loss
- ☐ Facial Asymmetry
- ☐ Rosacea
- ☐ Dry Skin
- ☐ Oily Skin
- ☐ Headaches
- ☐ Excessive Sweating
  - Location: _____
- ☐ Excess Hair
  - Location: _____

Other concerns? Tell us about it!

_____

_____

_____

_____

_____