Please Print

Client Registration and Medical History

Name: _____ **Date of Birth:** _____ **Age:**____
First MI Last

Address:_____
Street City State Zip

Home Phone: _____ **Work Phone**: _____

Cell Phone: _____ **Occupation**: _____

E-mail: _____ May we contact you via email? Y / N

Preferred method of contact: Home / Cell / Work / Email *(circle one)* **OK to leave a voice message?** Y / N

Emergency Contact Name: _____ **Relationship**: _____ **Phone**: _____

How did you hear about us? (*Please specify*) ☐ Friend (name)_____ ☐ Dr._____

☐ Website ☐ Newspaper ☐ Yellow Pages ☐ Magazine _____ ☐ Radio Station _____

☐ Other: _____

Please list any active **medical problems**:

_____

_____

Please list any **prescription medications** you use:

_____

_____

List any **over the counter medications** and/or **supplements**:

_____

_____

Medication allergies? ☐ No ☐ Yes _____

Have you seen a dermatologist / physician for your skin?

☐ Yes ☐ No (list why)_____

Do you have any of the following?

☐ Yes ☐ No **EVER had cold sores / herpes**?
☐ Yes ☐ No **Lidocaine Allergy**?
☐ Yes ☐ No **Egg Allergy**?
☐ Yes ☐ No **History of Skin Cancer**?
☐ Yes ☐ No **Polycystic Ovarian Syndrome?**
☐ Yes ☐ No **Easy Bruising?**
☐ Yes ☐ No **Auto-Immune Disorder?**
☐ Yes ☐ No **Seizure Disorder?**
☐ Yes ☐ No **Bleeding Disorder?**
☐ Yes ☐ No **Accutane** Date of last use: _____
☐ Yes ☐ No **Facial Surgery?** Type: _____
☐ Yes ☐ No **Deep Laser Resurfacing?**
☐ Yes ☐ No **Diabetes**
☐ Yes ☐ No **Tobacco Use:** Currently ___ per day /
Quit – How long ago? ___
☐ Yes ☐ No **Menopause?**
When did it begin?: _____
Hot Flashes? → Yes / No
Hormone Replacement? → Yes / No

Nationality / Ancestry: (check all that apply)

☐ English: % _____
☐ Irish: % _____
☐ Polish: % _____
☐ German: % _____
☐ French: % _____
☐ Scandinavian: % _____
☐ African: % _____
☐ Asian: % _____
☐ Greek: % _____
☐ Italian: % _____
☐ Native American: % _____
☐ Hispanic: % _____
☐ Other: % _____

I acknowledge that all information contributed by me is accurate to the best of my knowledge.

Signature: _____ Date: _____

Medical History Updated –

Signature: _____ Date: _____

Medical History Updated –

Signature: _____ Date: _____

Medical History Updated –

Signature: _____ Date: _____

Medical History Updated –

Signature: _____ Date: _____

Medical History Updated –

Signature: _____ Date: _____

Informed Consent

General Policies

This Informed Consent Form is intended to provide you with information needed to make an informed decision to undergo treatments provided by Lasting SkinSolutions.

General Policies

Before your treatment you will be evaluated to determine your candidacy for procedures. This evaluation or consultation is usually 30 to 60 minutes. Your medical history is reviewed along with your goals of treatment. We will generate a wish list and treatment plan as deemed applicable. Photographs are taken before and after each treatment to determine results. The treatment can last 15 to 45 minutes depending upon the treatments. Yearly treatments may be required to maintain results.

Please *initial* next to each line.

___ Our policy is to receive payment on the day of service unless the package has been pre-paid

___ Cancelled packages will result in forfeiture of a 10% Processing Fee and will be paid only on the discounted portion paid by the client

___ All appointments must be cancelled or re-scheduled at least 48-business hours in advance or will be subject to a $50 charge

___ We uphold to the right to obtain payment for services at the time of scheduling to hold the appointment time. This is non-refundable if you do not show for this appointment

___ We will charge a fee of $35 for any personal check returned to us due to non-sufficient funds

___ All unpaid invoices will accrue a monthly 1.5% finance charge (18% annual rate)

___ I understand that services provided at Lasting SkinSolutions are cosmetic in nature and do not claim to treat or cure any medical condition

___ I understand that medicine is not an exact science and results may vary. No guarantees have been expressed or implied.

I certify that I have read and fully understand the above consent and explanations. I have been given the opportunity to have all of my questions answered to my satisfaction regarding the above procedures by a Lasting SkinSolutions representative. By signing below, I acknowledge that I have been fully informed of the policies of Lasting SkinSolutions.

Patient Signature: _____ Date: _____

Witness Signature: _____ Date: _____

Re-Consent (Initials): _____ Date: _____ Witness (Initials): _____ Date: _____

Re-Consent (Initials): _____ Date: _____ Witness (Initials): _____ Date: _____

Re-Consent (Initials): _____ Date: _____ Witness (Initials): _____ Date: _____

Lasting SkinSolutions®

Name: _____ **Date:** _____

Thank you for visiting Lasting SkinSolutions. Please fill out the following questionnaire so we may better serve you.

I would like to see improvements in:

- ☐ Fine lines and wrinkles
- ☐ Wrinkles around the eyes
- ☐ Hollowness under the eyes
- ☐ Dark circles under the eyes
- ☐ Eye puffiness
- ☐ Fuller lips
- ☐ Tightening/Firming of the skin
- ☐ Brown Spots/Sun damage
- ☐ Uneven pigmentation
- ☐ Flushing/Redness of the face
- ☐ Melasma
- ☐ Rosacea/Broken capillaries
- ☐ Toenail fungus
- ☐ Enlarged pores/Clogged pores
- ☐ Blemishes
- ☐ Hormonal Symptoms
- ☐ Blackheads/Milia (white bumps)
- ☐ Acne/Acne Scars
- ☐ Scarring
- ☐ Overall skin color or tone
- ☐ Facial Skin Texture
- ☐ Softening of the skin
- ☐ Underarm/palm sweating
- ☐ Leg Veins
- ☐ Cellulite Appearance
- ☐ Weight
- ☐ Unwanted Hair on: (area)

Color of hair to be treated:
_____

My skin type is:

- ☐ Normal
- ☐ Oily
- ☐ Dry
- ☐ Combination
- ☐ Sensitive
- ☐ Acne Prone

I use the following skin care products:

- ☐ Daily face wash
- ☐ Daily moisturizer
- ☐ Toner
- ☐ Daily facial sunscreen
- ☐ Anti-aging products
- ☐ AHA/BHA acid products
- ☐ Topical Prescription Products

I would like to learn more about the following:

- ☐ Relaxers: Botox, Dysport, & Xeomin
- ☐ Intense Pulsed Light/Broad Band Light
- ☐ Injectable Fillers: Artefill®, Restylane®, Sculptra™, Radiesse™, Juvéderm™, and Perlane™
- ☐ Skin Tightening Procedures
- ☐ Skin Resurfacing Procedures
- ☐ Skin Rejuvenation
- ☐ Profractional Treatment
- ☐ Airbrush Face Lift
- ☐ Skin Care Products
- ☐ Leg Vein Treatments
- ☐ Hair Removal
- ☐ Sclerotherapy
- ☐ Cellulite appearance reduction
- ☐ Microdermabrasion
- ☐ Chemical Peels
- ☐ Wellness