premier aesthetic & laser centre

New Client Information & History Form

Today's Date: _____ / _____ / _____

Client Name: _____

Birth Date: _____ / _____ / _____ **Age:** _____ **Sex:** **M** **F**

Address: _____

City: _____ **State:** _____ **Zip Code:** _____

We may call you to confirm your appoint. Please use the numbers that you wish us to call.

Home: _____ **Cell Phone:** _____

Work: _____

Email Address: _____

We notify our customers about treatment specials and discounts on product via email. We do NOT disclose this information to anyone.

Reason for your visit: _____

How did you hear about us: _____

If referred by a friend, please let us know. We offer referral rewards.

What skin condition(s) are you interested in treating?

_____ Sun Damage _____ Age/Sun Spots _____ Dark Spots _____ Cherry Spots _____ Wrinkles/ Fine Lines

_____ Acne scars _____ Dull Skin _____ Acne _____ Large Pores _____ Spider Veins

_____ Varicose Veins _____ Loose Skin _____ Facial Veins _____ Excess Hair

_____ Rosacea/Redness of Skin Other: _____

What treatment(s) have you had in the past?

_____ Hair Removal _____ Botox _____ Dermal Fillers _____ Chemical Peels

_____ Vein Treatments _____ MicroLaser Peels _____ Cosmetic Surgery _____ Skin Rejuvenation

Other: _____

Your skin is: _____Oily _____Dry _____Resilient _____Sensitive _____ Unsure _____ T-Zone/Combination

What type of skin care product(s) are you using (if any)?

_____ Topical Antibiotics _____ Renova _____ Alpha Hydroxyl _____ Glycolic Acids

_____ Obagi Skin Care _____ Steroid Creams _____ Bleaching Creams _____ Retin A

_____ SkinMedica Skin Care _____ Tazorac Other: _____

Prior or current medical conditions:

_____	Heart Disease	_____	Arrhythmia	_____	Blood Clots
_____	Pregnant / Lactating	_____	Seizure Disorders	_____	Diabetes
_____	Skin Disorders	_____	Cancer	_____	Excessive Sun Exposure
_____	Acne	_____	Suspicious Moles	_____	Gold Treatments
_____	Bleeding Tendency	_____	Hernia	_____	Connective Tissue Disorder/Autoimmune Disease
_____	History of Hypertrophic scaring (thick raised scars)			_____	Use of Blood Thinners, Aspirin or Anti-Inflammatory
_____	Taking Mood Altering or Depression Medications			_____	Active Inflammation
_____	Communicable Disease, e.g. MRSA			_____	HIV or Exposure to person with known HIV
_____	Hepatitis or known exposure to Hepatitis A, B. or C			_____	History of Accutane use (in the past few months)
_____	Vitiligo or Family History of Vitiligo			_____	Other: _____

Medications:

_____	Aspirin	_____	Plavix	_____	Insulin	_____	Cortisone	_____	Herbals
_____	Sedatives	_____	Accutane	_____	Antibiotics	_____	Coumadin	_____	Anti-Inflammatory
_____	Hormones/Contraceptives			_____	Thyroid Medication	_____	Vitamin E		
_____	Anti-Oxidants	Other:	_____						

Allergies:

Lidocaine _____ No _____ Yes (if yes, please describe) _____

Latex _____ No _____ Yes (if yes, please describe) _____

Skin Conditions or Allergies: _____

Tobacco Use: ____No ____Yes____Quit; **Alcohol Use:** ____No ____Yes____Occasional

List any surgeries you have had and year: _____

_____ _____

Following a cosmetic procedure, how much time are you able to take off and avoid strenuous physical activity or extended travel? _____ No time off work _____ 1 Day _____ 2 days _____ 3 days _____ 1 week _____ 2 or more weeks

Are there other issues/areas that you would be interested in treating in the future?

_____	Sun Damage	_____	Acne Scars	_____	Age/Sun Spots	_____	Acne	_____	Facial Veins
_____	Dark Spots	_____	Dull Skin	_____	Loose Skin	_____	Large Pores	_____	Cherry Spots
_____	Wrinkles/Fine Lines			_____	Rosacea / Redness of Skin				

The information on this form is correct to the best of my knowledge.

Client's Signature: _____

Thank you for visiting with us. We look forward to making you look and feel your best!

Rev3.2013pc

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Photography Authorization & Privacy Policy

Patient's Name: _____ **Date of Birth:** _____

The use of photographs is essential to the planning and evaluation of cosmetic procedures. Your service related site may be documented photographically before and after the procedure. These photographs will become part of your permanent medical record and will not be shown to anyone not affiliated with Premier Aesthetic & Laser Centre without your consent.

For various reasons our physicians are often asked to show before and after photographs of patients. Many satisfied patients have granted permission to use their photographs anonymously. We ask that you might consider doing so as well. We make every attempt to represent our clients accurately with integrity and dignity in all media.

"Specific Situation(s)" Authorization

_____ Yes _____ No For our clients: I recognize that prospective patients will ask to look at before and after photographs in the process of choosing a physician and evaluating specific procedures. I authorize the use of my photographs for this purpose.

_____ Yes _____ No For our medispa marketing: I authorize the use of my photographs in seminars, health fairs, and conferences, for interested and/or prospective patients.

_____ Yes _____ No For public marketing: I authorize the use of my photographs on the internet or on television.

_____ _____

Patient's Signature ***Date***

Notice of Privacy Policy

Acknowledgement of Notice of Privacy Practices:

I hereby acknowledge that a copy of the Notice of Privacy Policy was made available to me by Premier Aesthetic & Laser Centre on the date indicated below.

_____ _____

Patient's Signature ***Date***