CENTER FOR *Facial* REJUVENATION

Client Information and Medical History

Personal History:

First Name_____ Middle Initial____ Last Name_____

Date of Birth_____/_____/_____ Age_____ Social Security Number _____

Address_____ City_____ State_____ Zip_____

Home Phone_____ Cell_____ Email_____

May we leave a message?: Yes/No on Home/Cell

Occupation/Employer _____

Emergency Contact _____ Phone _____

How did you hear about us? _____

Medical History: Do any of the conditions apply to you? (please circle yes or no)

Currently Pregnant	yes	no	Prone to cold sores/fever blisters	yes	no
Attempting pregnancy	yes	no	Seizure Disorder	yes	no
Breast Feeding	yes	no	Hormone imbalance	yes	no
Hepatitis	yes	no	Thyroid imbalance	yes	no
Cancer(skin or other)	yes	no	Pacemaker/heart problems	yes	no
Diabetes	yes	no	Metal pins/plates/etc	yes	no
Hypertension	yes	no	Blood clotting abnormalities	yes	no
HIV/AIDS	yes	no	Any active infection	yes	no
Lupus/autoimmune dz.	yes	no	Wear contacts	yes	no
Keloid scars	yes	no	Erythema abigne/other skin rash	yes	no
Alopecia/Trichotillomania	yes	no	Glaucoma	yes	no
Refractory eye surgery	yes	no	Dry eyes	yes	no

MRSA yes no If yes, presently or past history? _____

List all medications, supplements, vitamins, diuretics, etc., that you are currently taking or have taken in the last 3 months: _____

_____

_____

List all <u>allergies</u> including cosmetics, foods, drugs, fragrances, etc.: _____

_____

_____

Does your skin have hyper-pigmentation (dark spots) or hypo-pigmentation (light spots)? yes no

If yes, explain _____

Have you undergone surgery, cosmetic enhancements (botox/fillers), and/or permanent makeup procedures? yes no /

If yes, what type and how long ago _____

Do you smoke? yes no If yes, how many packs/day _____

Do you drink? yes no If yes, how often _____

Do you take birth control pills? Yes no If yes, what kind _____

Rate your stress level on a scale of 1 to 5 (1=low stress, 5=high stress): _____

Do you exercise? yes no If yes, how often _____

How many 8 oz. glasses of water do you consume each day? _____

Skin Type I	Never tans, always burns (extremely fair skin, blonde hair, blue/green eyes)
Skin Type II	Occasionally tans, usually burns (fair skin, sandy/brown hair, green/brown eyes)
Skin Type III	Often tans, sometimes burns (medium skin, brown hair, brown eyes)
Skin Type IV	Always tans, never burns (olive skin, brown/black hair, dark brown/ black eyes)
Skin Type V	Never burns (dark brown skin, black hair, black eyes)
Skin Type VI	Never burns (black skin, black hair, black eyes)

Skincare Information:

Please circle any of the following prescription skincare products used in the last three months:

Accutane Retin-A Tretinoin Atralin Avita Retinol

Tazorac Ziana Azelex Differin

Please explain how frequently you use the above products and list any other skincare prescriptions taken topically or orally: _____

_____

_____

Do you sun bathe or use tanning beds? yes no

Do you use sunscreen? yes no

Do you use self-tanners? yes no

Do you have a tendency to redness or flushing of the skin? yes no

Please circle what you feel best describes your skin type:

Normal Dry/Dehydrated Oily Combination Acne Prone Sensitive

What skincare products are you currently using? _____

_____

Have you had any chemical peels, microdermabrasion, or any resurfacing treatments in the last month? yes no

If yes, which treatment and when _____

Have you used any of the following hair removal methods in the past 6 weeks? (Please circle all that apply)

Shaving Waxing Electrolysis Tweezing Stringing Depilatories (Nair)

Client Acknowledge and Agreement

I certify that the information given is true to the best of my knowledge and certify that I will notify the office immediately if any changes occur in my medical history/health status.

Cancellation Policy

Since we have reserved a medical provider just for you, please understand that we will assess a $50 cancellation fee in the event you cancel without a 24 hour notice.

Photography

I hereby authorize and consent to having photographs taken of me. I understand that they must be used as an aid for treatment purposes and that any photographs taken will remain the property of Center for Facial Rejuvenation. I also understand that my name in association with my photos will remain strictly confidential.

Payment

I assume full responsibility for the payment of any and all services rendered by Center for Facial Rejuvenation and will pay full amount at the time of service. Furthermore, I acknowledge and agree that I am responsible for any collection agency costs, court costs, or attorney's fees incurred by Center for Facial Rejuvenation in collecting any outstanding balance for services rendered to me.

Client Signature _____ **Date** _____

_____ YES... I would like to receive a copy of CFR's Privacy Policy
_____ No... I would not like to receive a copy of CFR's Privacy Policy

CENTER FOR
Facial
REJUVENATION

REFERRAL PROGRAM CONSENT

DISCRIPTION OF PROGRAM

This consent form authorizes Center for Facial Rejuvenation to include you in our Referral Program. Our Referral Program offers clients the opportunity to receive 5 units of Botox free or $50 off any syringe of filler when you refer a friend to our practice (and they spend at least $150). There are no limits. No restrictions.

CONSENT

I understand that this Referral Program gives Center for Facial Rejuvenation the authorization to use my name as it pertains to the program to benefit the referral source only. I understand that my medical history will not be released to any individual without further consent.

I release and hold harmless Center for Facial Rejuvenation, staff and consultants form any liability in connections with any use involving this program.

___ I FORMALLY DECLINE

___ I FORMALLY ACCEPT (if accepting, please sign and print below)

_____ _____

Signature of Patient Printed Name

_____ _____

Signature of Witness Date