

Renaissance Aesthetics

Hair & Vein Removal • Sun Spot Removal • Skin Care • Skin Rejuvenation

Name: _____ Today's Date: ____/____/____
Last First Mo Day Yr

Address: _____ Birthdate: ____/____/____
Mo Day Yr

City: _____ State: _____ ZIP: _____

Best phone number to contact you regarding your treatment and where we may leave a message:

Home:() _____ Cell:() _____ Work:() _____

How did you hear about us? _____

Primary Care Physician _____ PCP Phone Number _____

This information is necessary for your procedure. Please answer yes or no to the following questions:

YES NO

- Are you using any prescribed medications? List _____
- Are you using any herbal medications? List _____
- Do you take oral anti-coagulant (blood thinning) medication or aspirin? List _____
- Are you allergic to any cosmetic ingredients, medications or foods? List _____
- Are you pregnant or trying to become pregnant?
- Do you use oral contraceptives?
- Do you use hormone replacement therapy?
- Do you smoke? How much? _____ How long? _____
- Do you spend a lot of time outdoors or use a tanning bed often?
- Do you have any tattoos or permanent makeup?
- Accutane Use _____

Please tell us your main concerns that brought you to our office today: _____

In addition to the above, please tell us which skin conditions concern you the most (Check all that apply):

- | | | |
|---|--|---|
| <input type="checkbox"/> Sun Damage | <input type="checkbox"/> Brown spots (Hyperpigmentation) | <input type="checkbox"/> White spots (Hypopigmentation) |
| <input type="checkbox"/> Uneven skin tone | <input type="checkbox"/> Visible exposed blood vessels | <input type="checkbox"/> Hard bumps under skin |
| <input type="checkbox"/> Enlarged pores | <input type="checkbox"/> Clogged pores | <input type="checkbox"/> Blackheads/Whiteheads |
| <input type="checkbox"/> Acne | <input type="checkbox"/> Excessive oiliness | <input type="checkbox"/> Pimples |
| <input type="checkbox"/> Upper lip lines | <input type="checkbox"/> Wrinkles | <input type="checkbox"/> Scarring |
| <input type="checkbox"/> Sun Spots | <input type="checkbox"/> Dry patches | <input type="checkbox"/> Unwanted Hair |
| <input type="checkbox"/> Other: _____ | | |

What is your skin type: Dry Combination Oily Normal

How much water do you consume per day? _____

Please check the products you currently use and list the BRAND NAMES of Cosmetic Products:

- Cleanser _____ Soap _____ Toner _____
 Moisturizer _____ Night Cream _____ Mask _____
 Eye cream _____ Astringent _____ Glycolic Wash/Cleanser
 Scrub _____ Sunscreen _____ Salicylic Wash/Cleanser
 Vitamin A Cream Vitamin C Creams Alpha or Betahydroxy Cream

Are you using any topical creams, lotions or oral antibiotics for acne, skin cancer, anti-aging or hyperpigmentation?

Yes No

If yes, please list _____

Have you ever had any of the following wrinkle fillers or implants?

- Collagen Restylane Perlane Hylaform Sculptra Juvaderm Silicone Radiance
 Other: _____

* If so then when was it done? _____ What area? _____ By whom? _____

Please check any health problems, past or present:

- Seizures Liver disease Skin cancer (Type: _____)
 Hormonal Problems Diabetes Cystic Acne Thyroid problems Cancer
 High Blood Pressure Heart problems Collagen Sarcoidosis Hepatitis
 Vasovagal Syncope PCOS Auto immune disease/disorder Asthma
 Other: _____

Do you have any of the following chronic skin disorders?

- Psoriasis Dermatitis Eczema Keloid Scarring
 Fever Blisters Cold Sores Sun Blisters Herpes Simplex/Blisters

Have you ever undergone any of the following treatments?

- Macrodermabrasion Acid Peel Cosmetic Surgery Lasers Botox Accutane
 Microdermabrasion

When and where was it done? _____

Are you currently removing hair by any of the following methods?

- Waxing Tweezing "Nair" type products Electrolysis

- If so when was it done _____ what area _____ and what type of laser? _____

Do you have any allergies? No Yes If yes, please list: _____

Are you allergic to latex or latex products? No Yes

I certify that the above information is correct to the best of my knowledge.

Client's signature

Date

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OFFICE POLICIES

Please read and initial each paragraph signifying you understand the following policies.

_____ I have been notified and fully informed that the procedure to be done is a cosmetic procedure as defined by the insurance industry. I understand that cosmetic procedures/services are determined to be “not medically necessary”. This procedure cannot be filed with any insurance company for payment or reimbursement by myself or any other party. I hereby agree to be held personally and fully responsible for payment of the entire procedure.

_____ I understand that cosmetic procedures are not an exact science. Although our staff strives for the best results with all treatments, the efficacy may vary among individuals. I may see excellent results, partial results, or no results. Refunds will not be requested or expected by me.

_____ I understand that children and guests are not permitted in any procedure room for any reason due to significant medical and safety risk. Children under 10yrs. old are not permitted unattended in the waiting room at any time. Staff members are not permitted to supervise children.

_____ I have read and understand the consent(s) form(s) pertaining to my procedure(s). I agree to hold harmless and release from any liability Renaissance Aesthetics or any of its officers, or employees for any condition or result, known or unknown that may arise as a result of any treatment that I receive.

_____ I understand photos will be taken before, during and after any procedure for documentation in my medical record.

I have read and understand the above stated policies.

Client's signature

Witness

Date