Patient Intake Form

Name:_____Date of Birth: ___/___/___ Date: ___/___/_____

Email (Please Print) _____

Address: _____City: _____ State: ____Zip:_____

Home Phone: _____ Cell:_____ Work Phone:_____

Emergency Contact: _____Phone Number: _____

How did you hear about us? (Please check all that apply.)
Friend_____ Relative _____ Web Search _____ Newspaper_____ Radio _____
Facebook____ Television _____ Drive-by _____ Billboard_____
Other (please explain):_____
If friend/relative, who may we thank for the referral _____

SKIN CARE/What is your daily skin care

regimen?_____

_____

Which of the following best describes your skin? (Please circle all that apply)

Oily skin Combination Skin(oily in T-zone, dry to normal cheeks) Dry skin

Large pores Excessive hair growth Redness Sensitive skin

SUN HISTORY & LIFESTYLE
How often do you work outdoors?
____Frequently ____Occasionally ____Rarely ____Never
How often do you use a sunscreen?
____Frequently ____Occasionally ____Rarely ____Never
How often do you use tanning beds?
____Frequently ____Occasionally ____Rarely ____Never

PREVIOUS PROCEDURES Which of the following have you had in the past? (Please circle all that apply)

Facials Botox Fillers (Juvederm/ Radiesse/Restalyne/Voluma) Skin Tightening

Chemical Peels Tattoo Tattoo Removal Microdermabrasion Electrolysis

Waxing/Threading Laser Hair RemovalPermanent Make-Up Skin Resurfacing

Cellulite/Circumference Reduction Facial Plastic Surgery Plastic Surgery (body)

Patient Signature_____ **Provider Signature** _____