MEDAESTHETICS

PATIENT REGISTRATION

Name: _____ DOB: _____

Address: _____

City: _____ State: _____ Zip: _____

Home #: _____ Cell #: _____ Email Address: _____

How did you hear about us? _____ May we contact you by email: _____Yes _____No

Emergency Contact Name and Phone #: _____

What conditions currently apply to your skin?

☐ Acne/Acne Scars	☐ Unwanted Hair	☐ Age Spots
☐ Uneven skin tone	☐ Facial Capillaries	☐ Wrinkles
☐ Hyperpigmentation	☐ Enlarged Pores	☐ Fine Lines

Indicate which treatments you are interested in:

☐ Scar Revision	☐ Laser Hair Removal	☐ Laser Vein Therapy	☐ Nail Fungal Treatment
☐ Hair Regrowth	☐ Skin Rejuvenation	☐ Botox/Fillers	☐ Tattoo Removal
☐ Fat/Cellulite Reduction	☐ Body Contouring	☐Permanent Makeup	☐ BBL

Areas of interest for treatment (check all that apply):

☐ Lip	☐ Bikini	☐ Upper Back	☐ Shoulder	☐ Hands
☐ Chin	☐ Underarm	☐ Lower Back	☐ Abdomen	☐ Feet
☐ Sideburns	☐ Lower Legs	☐ Buttocks	☐ Chest	☐ Upper Arms
☐ Forehead	☐ Upper Legs	☐ Areolas	☐ Neck	☐ Lower Arms

Have you ever been diagnosed with any of the following?

☐ Rosacea	☐ Keloid Scarring	☐ Bleeding Disorder
☐ Cold Sores	☐ Diabetes	☐ Heart Condition
☐ HIV/AIDS	☐ Cold Sores	☐ Auto Immune Disorder
☐ PCOS	☐ Hirutism	☐ Allergies: _____

Past Medical Illness (Please list): _____

Past Surgeries (please list): _____

Medications/ Medical Treatment:

Have you ever had laser treatments before? ☐ Yes ☐ No

Are you currently taking birth control pills? ☐ Yes ☐ No

Are you currently pregnant or breast feeding? ☐ Yes ☐ No

Have you taken Accutane? ☐ Yes ☐ No If yes, how long ago? _____

Do you Use Acne Medication? ☐ Yes ☐ No If yes, please list: _____

Other Prescription Medication? ☐ Yes ☐ No If yes, please list: _____

Do you consume alcohol? Yes No Do you smoke? Yes No

Do you exercise regularly? Yes No Do you tanning booths/creams? Yes No, how long ago? _____

I understand and agree that the cosmetic services provided by Med Aesthetics, LLC are elective in nature and not covered by medical insurances. Therefore, payments are due in full at the time the services are rendered because of the elective nature of these treatments. I understand that there is a no refund policy for any services or treatments rendered.

Because each appointment time is reserved for me and therefore cannot be used for another client, there may be a $50.00 charge or forfeit treatment session on pre purchased package for missed appointments unless I cancel two (2) business days in advance. I further understand that there is a $35.00 charge for any returned checks. By signing this statement, I agree to the terms above.

Signature _____ **Date** _____