METABOLIX
WELLNESS CENTER

Name _____ Date of Birth _____
(First) (MI) (Last) (Month/ Day/ Year)

Address _____
(Street/apt) (City) (State) (Zip code)

Cell Phone: _____
I consent to be reminded of my appointments via text message: Yes / No

Email:_____
I consent to the email address being used for appointment reminders as well as added to the Metabolix Wellness email newsletter, where I will get information on specials and promotions

How did you hear about us?_____

Occupation _____

Emergency Contact: _____ Phone _____

I request that medical information, test results, or messages:

(INITIAL below all that apply)
_____ be given only to me directly in person or over the phone
_____ be left on my home/cell answering machine/voice mail
_____ be mailed to my mailing address listed above
_____* be emailed to me at _____
* I understand that email is not secure and may be intercepted by unauthorized people and possibly made available on the internet. Understanding this possibility and that you have advised me that you would prefer to send my confidential information by mail, I still request that you email me the confidential information to the above email address.

I consent to medical treatment. I agree to pay all charges for myself, and for members of my family, as applicable, promptly upon presentation thereof. Charges as shown by statements are agreed to be correct unless protested in writing within thirty days. It is agreed that payments will not be delayed or withheld because of insurance coverage or the pendency of claims thereon. In the event that legal action should become necessary to collect an unpaid balance due, I agree to pay reasonable attorney fees or other such costs as the Court determines proper.

_____ _____
Patient Signature Date

Continued on Back

AESTHETIC/ MEDICAL HISTORY

Please list all injectable procedures (Botox, Juvederm, Restylane, Collagen, etc.) and last date performed:

_____

Please list all prior surgical procedures and dates performed:

_____

Past/ Current Medical Conditions:

_____

_____

Do you have a Pacemaker/ Defibrillator?.....
Have you taken Accutane, Retin A in the past 12 months?.....
Are you currently taking Coumadin, Aspirin or other blood thinners?.....
Do you require antibiotics before procedures such as dental cleanings?.....
Do you have history of cold sores?.....
Do you smoke?.....
Are you pregnant?.....
Are you nursing?.....

Medication **ALLERGIES**: _____

Please list current prescription medications and any over-the-counter medications or vitamin supplements taken at least once daily:

_____

_____

Have you ever had an adverse reaction to laser or cosmetic treatments? _____

Have you ever had an adverse reaction to topical numbing medication (Lidocaine)?

Important: What skincare products do you use on your face daily? (check all that apply)

Name of Skincare Brand(s) You Use: _____

- ☐ **cleanser**
- ☐ **toner**
- ☐ **eye cream**
- ☐ **vitamin C product**
- ☐ **hydroquinone (skin 'bleaching' cream)**
- ☐ **retinol or trentinoin product**
- ☐ **daily sunscreen protectant**
- ☐ **other: _____**