



Name		Date of Birth	
Address			
(Street/apt)	(City)	(State)	(Zip code)
Cell Phone:			
Email:			
I consent to the email address being used for newsletter, where I will get information on a		well as added to the Pa	riority You email
How did you hear about us?			
Occupation			
Emergency Contact:	Phone	2	
I request that medical information, test	results, or messages:		
( <u>INITIAL</u> below all that apply)			
be given only to me directly in pe	erson or over the phone		
be left on my home/cell answering	g machine/voice mail		
be mailed to my mailing address	listed above		
* be emailed to me at			
* Lunderstand that email is not secure a	nd may be intercepted by	unauthorized peop	le and possibly mad

\* 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.

## 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?	Yes / No
Have you taken Accutane, Retin A in the past 12 months?	Yes / No
Are you currently taking Coumadin, Aspirin or other blood thinners?	Yes / No
Do you require antibiotics before procedures such as dental cleanings?	Yes / No
Do you have history of cold sores?	Yes / No
Do you smoke?	Yes / No
Are you pregnant?	Yes / No
Are you nursing?	Yes / No

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)	? YES/ NC
What skincare products do you use on your face?	

Are you interested in a *Complimentary* Skin Consultation to learn about: IPL photofacials, Chemical Peels, Microdermabrasion, Dermaplaning, PRP or getting started on ZO by Zein Obagi medical grade skin care? YES/ NO