PATIENT INFORMATION

Name _____ **Date** _____

Address _____ **Apt/Ste** _____

City _____ **State** _____ **Zip** _____

Home# _____ **Cell#** _____ **Work #** _____

Occupation _____

Email _____**Receive email updates/promotions?**___**Yes**___**No**

Appointment confirmation? **Home** ___ **Work** ___ **Cell** ___ **Email** ___

Date of Birth _____ **Marital Status** _____ **Children** _____

Emergency Contact _____ **Phone#** _____

Who may we thank for referring you? _____

Treatment desired & Reason? _____

CANCELLATIONS

Your scheduled appointment is reserved exclusively for you. Should you need to cancel or reschedule your appointment, please notify us 24 hours in advance if at all possible. We reserve the right to charge $75 for appointments cancelled or broken without 24 hours advance notice.

Client Signature _____ Date _____

Witness Signature _____ Date _____

CONSENT AND AGREEMENT

I certify that the above statements are true and correct, and that I, having been fully advised by Blush Aesthetics and Skincare concerning the nature of the treatment process proposed to be administered by them, hereby authorize and direct them to administer such procedures as may be deemed necessary or advisable. My signature below constitutes my acknowledgement that (1) I have read, understand and fully agree to the foregoing consent; (2) the proposed treatment process has been satisfactorily explained to me and I have all the information which I desire; and (3) I hereby give my consent and authorization and release this establishment and its agents of any claims that I have in the future in connection with the described treatment.

Client Signature _____ Date _____

Witness Signature _____ Date _____

CONSENT TO PHOTOGRAPH

The undersigned hereby authorized Blush Aesthetics and Skincare to photograph and agrees that the negatives, print, or digital images prepared therefrom may be used for the purposes checked: ☐ Medical Record ☐ Education and/or Demonstration ☐ Other specified: _____

I have read and understand this agreement.

Client Signature _____ Date _____

PATIENT INFORMATION

Name _____ Date _____

Do you have any medical conditions? _____

Do you have any allergies? (please list) _____

Are you pregnant? _____ If so, How many months? _____

MEDICATION *DOSAGE* *REASON*

Are you currently taking any medications? _____

_____

_____

Do you currently have any heart conditions? _____

Please check all that apply to you:

___ Pacemaker
___ Pregnancy
___ Cancer If yes, please explain: _____
___ Hepatitis If yes, please explain: _____
___ HIV
___ Depression
___ Anxiety Disorder If yes, please explain: _____
___ Tumors
___ Epilepsy
___ Heart Conditions If yes, please explain: _____
___ Inflammation/Infection If yes, please explain: _____
___ Autoimmune Disorder If yes, please explain: _____
___ Lupus
___ Herpes Simplex Virus
___ Varicose Veins
___ Allergy to rubber/metal
___ Lack of normal skin sensation
___ Skin Diseases If yes, please explain: _____
___ Thrombosis/Phlebitis
___ Metal Implants/Screws If yes, please explain: _____
___ Prosthesis/Silicone If yes, please explain: _____
___ Acne

Any other medical condition not listed? _____

COSMETIC HISTORY:

Have you had any cosmetic procedures in the area you are seeking treatment? If yes, please explain: _____

_____

Have you ever had any complications as a result of any cosmetic procedure(s)? If yes, please explain: _____

_____

Have you recently had any Botox or soft tissue fillers (i.e. Restylane, Juvaderm, Voluma, etc) in the area you are seeking treatment? If so, please explain: _____

Do you take or use Accutane? ___ Retin-A? ___ Glycolic Acid? ____

What skin care products do you currently use? _____

When did you last use these? _____