

PATIENT INFORMATION

Name _____ Date _____

Address _____ Apt/Ste _____

City _____ State _____ Zip _____

Home# _____ Cell# _____ Work # _____

Occupation _____

Email _____ Receive email? Yes No

**MUST opt-in to receive Appointment Reminders, Birthday Gift, and Client Referral Credits*

Receive TEXT MESSAGES? Yes No

**You will receive Appointment Reminders 2 days in advance, and we ask that you reply "C" to confirm receipt.*

Date of Birth _____ Marital Status _____ Children _____

Emergency Contact _____ Phone# _____

Who may we thank for referring you? _____

Treatment desired & Reason? _____

*Credit Card # to Reserve Future Appointments _____

Expiration ____/____ CVV _____

Required to be seen today and to book any future appointments

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 **\$99** for appointments cancelled or missed/rescheduled **without 24 hours advance notice.**

Client _____ Date _____
Signature _____
Witness _____ Date _____
Signature _____

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 _____ Date _____
Signature _____
Witness _____ Date _____
Signature _____

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 _____ Date _____
Signature _____

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
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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? _____