SKIN • 101
medical spa

Patient Registration Information

Please print, sign and date all Highlighted areas upon completion. Should you have questions, or need assistance completing the following documents, a member of our staff is available to assist you.

Name:_____
First: Last Name: M.I.

Nickname _____ Date of Birth: ____/____/_____ Age: _____ Sex: M F
month day year 4 digits

Home Address:_____City:_____State:_____ Zip:_____

Home Phone: (_____)_____Cell Phone: (_____)_____Other: (_____)_____

Occupation/ Place of Employment:_____Email Address: _____

Name of Parent or Guardian (if patient is a minor):_____

Pharmacy Name & Phone Number:_____

How did you hear about us/Referred by?_____

Please circle any items bellows that you have any concerns about

Cellulite on Leg/Buttock	Dark Spots on Face/Neck/Arm	Scarring
Stretch marks	Abnormal Nail Appearance	Skin Tags
Wrinkles/Fine Lines	Leg Veins	Unwanted Hair
Excess Fat Around Midsection	Warts	Dryness
Rosacea	Acne	Other: _____

General Consent to Treat: I request treatment from SKIN 101 Medical Spa and authorize the facility and employees to provide care. I request and consent to medical care and diagnostic procedures that SKIN 101 Medical Spa determine necessary. I authorize SKIN 101 Medical Spa's employees to retain or dispose of any specimen or tissue taken from the above named patient. **Patient Initial:_____**

Payment Information Office Policy: Payment is expected at time of visit for any deductible, co-payments, unpaid insurance balance and any cosmetic procedures or skin care products. We appreciate your cooperation in settling your account at each office visit. If your insurance plan is responsible for payment, please present your current insurance card to our reception desk. A $20.00 fee will be charged for each insufficient funds check returned. **Patient Initial:_____**

Cancellation Policy: SKIN 101 Medical Spa requires a 24 hour notice for cancellations and/or changes to your appointment. If this notice is not given a $50 fee will be added to your account and will be collected before future appointments can be made. **Patient Initial:_____**

I. Medical/Surgical History:

Do you have now or have you ever had:

	Yes	No
Hypertension (high blood pressure)		
Diabetes (high blood sugar)		
Thyroid (hypo or hyper)		
Asthma		
Tuberculosis		
Hay fever/Seasonal Allergies		
Seizures		
Stroke Or Mini-Stroke		
Heart Attack/Angina		
Pacemaker		
Heart Murmur/Palpitations		
Kidney/Bladder Problems		
Prostate Problems		
Glaucoma		
Hepatitis/Liver Disease		
Recurrent Yeast Infections		
Bowel Disease/Colitis/Crohn's		
Frequent/Sever Headaches		
Cancer		
Radiation		
Artificial Joint or Heart Valve		
Past Surgery		

If YES to any above, please explain:

II. Current Health:

	Yes	No
Do you smoke?		

How much? _____

	Yes	No
Do you drink alcohol?		

How much? _____

	Yes	No
Do you use drugs?		

How much? _____

III. Medications

List all medications you are taking, including any over-the-counter herbals or vitamins:

IV. Dermatologic History:

Do you have now or have you ever had

	Yes	No
Keloids/Abnormal Scaring		
Poor Wound Healing		
Accutane Use (past or present)		
Skin Pigmentation Problems		
Reaction To Local Anesthetics		
Cold Sores/Herpes Infections		
Eczema		
Psoriasis		
Abnormal ("Dysplastic") Moles		
Precancerous Spots		
Skin Cancer – Melanoma		
Skin Cancer – Basal Cell		
Skin Cancer – Squamous Cell		
Abnormal Cold Sensitivity		
Abnormal Sun Sensitivity		
Cosmetic Surgery		
Rosacea		

If 'Yes' to any above, please explain:

V. Allergies: ☐ YES ☐NO

Are you sensitive / allergic to any oral medications? **Including: Papaya, Almond, Pumpkin, Latex, Sulfa, Benzoyl Peroxide.**
Please List:

VI. Family History

Do you have a family history of:

	Yes	No
Allergies/Asthma		
Skin Cancer – Melanoma		
Abnormal ("Dysplastic") Moles		
Skin Cancer – Basal/Squamous Cell		
Other Skin Disorder		

VII. Females

	Yes	No
Excess Facial/Body Hair		
Regular Menstrual Periods		
Are you pregnant or nursing?		

Provider initial_____ Date_____