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:__________**

SKIN • 101
medical spa

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**___________

SKIN • 101 medical spa

Score	Questions	0	1	2	3	4
	What is your eye color?	Light blue or Light green	Blue, Hazel Green	Blue	Brown	Dark Brown
	What is your natural hair color?	Sandy red	Blonde	Chestnut, Dark blonde	Dark brown	Black
	What is the color of your skin (unexposed)	Reddish	Very fair	Fair/beige w/ olive tint	Light brown Olive	Dark brown
	Do you have freckles on sun exposed areas?	Many	Several	Few	Incidental	None
	What happens when you stay in the sun too long?	Painful redness, blistering, peeling	Blistering followed by peeling	Burns sometimes with peeling	Rarely burn	Never burn
	To what degree do you turn brown?	Hardly or not at all	Light tan color	Reasonable tan	Tan very easily	Turn dark brown quickly
	Do you turn brown after several hours in the sun?	Never	Seldom	Sometimes	Often	Always
	How does your face respond to the sun?	Very sensitive	Sensitive	Normal	Very resistant	Never had a problem
	When did you last expose your skin to the sun, tanning bed, or self-tanning creams?	More than 3 months ago	2-3 months ago	1-2 months ago	Less than one month ago	Less than two weeks ago
	Do you expose the area to be treated to the sun?	Never	Hardly ever	Sometimes	Often	Always
Score:	Skin Type:	0-7 I	8-16 II	17-25 III	26-30 IV	>30 V and VI

Race:	American Indian or Alaska Native	Asian	Black or African American	Native Hawaiian or other Pacific Islander	White

Ethnicity: ______________________________________

Client Name:_____________________________________Client DOB:______________