SkinMedix®

NEW PATIENT INFORMATION

FIRST NAME | LAST NAME | MIDDLE

DATE OF BIRTH | AGE

STREET ADDRESS | APT# | CITY | STATE | ZIP

CELL PHONE | ALT PHONE

SPOUSE OR EMERGENCY CONTACT | EMERGENCY CONTACT PHONE

EMAIL

❏ CHECK HERE IF YOU WOULD LIKE MONTHLY SPECIALS SENT VIA EMAIL

HOW DID YOU HEAR ABOUT US? (please check)

❏ GOOGLE ❏ YAHOO ❏ YELP ❏ FACEBOOK

❏ INSTAGRAM ❏ BEST BUYS GUIDE ❏ WALK BY

❏ FRIEND REFERRAL: ____ (They will received a $20 Credit!}

REDEEMING REWARDS POINTS: BRILLIANT DISTINCTIONS AND ASPIRE REWARDS, ARE THIRD PARTY PROGRAMS AND IT IS YOUR RESPONSIBILITY TO HAVE YOUR POINTS REDEEMED AND READY PRIOR TO YOUR APPOINTMENT.

PAYMENT POLICY: WE ACCEPT CASH, CREDIT CARDS AND DEBIT CARDS. WE DO NOT ACCEPT CHECKS.

CANCELLATION POLICY: I UNDERSTAND THAT I NEED TO PROVIDE 24 HOUR NOTICE OF AN APPOINTMENT CHANGE. CANCELLING SAME DAY WILL BE CHARGED A $25.00 FEE AT YOUR NEXT SCHEDULED APPOINTMENT.
A NO-CALL, NO-SHOW WILL BE CHARGED A $75.00 FEE AT YOUR NEXT SCHEDULED APPOINTMENT.

SIGNATURE | DATE

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GOOD FAITH EXAM

Do you have any known allergies? *(check all that apply)*

❏ Latex ❏ Sulfa ❏ Caine based drugs (i.e. Lidocaine, Tetracaine, etc.)

❏ ______________________________

Do you or a family member have or have had any of the following? *(check all that apply)*

❏ Asthma ❏ Eczema ❏ Amyotrophic Lateral Sclerosis

❏ Facial Nerve Palsy ❏ Hay Fever ❏ Lambert-Eaton Syndrome

❏ Motor Neurophathy ❏ Myasthenia Gravis ❏ Sinus Problems ❏ Thyroid Disease

❏ Active Skin Disease ❏ Anemia ❏ Bleeding Disorder ❏ Blood Pressure Problems

❏ Bowel Disease ❏ Cardiac Disease ❏ Connective Tissue ❏ Cold sore/Herpes/Blisters

❏ Deep Dermal Scarring ❏ Diabetes ❏ Heart Disease ❏ Hepatitis A B or C

❏ HIV/AIDS ❏ Keloid Scars ❏ Liver Disease ❏ Lupus

❏ Metal Implants ❏ Seizures ❏ Skin Cancer ❏ Stomach Ulcers

❏ Hypersensitivity to Botulinum A toxin products

❏ Infection at the proposed injection site(s)

Do you take or have recently been on these medications? *(check all that apply)*

❏ Accutane ❏ Aminoglycosides ❏ Antibiotics ❏ Anti-Platelet Agents

❏ Anticholinesterases ❏ Curare (non depolarizing blockers) ❏ Lincosamides

❏ Magnesium Sulfate ❏ Photosensitizing Medications ❏ Taking Steroids ❏ Polymyxins

❏ Retin-A/Bleach Cream ❏ Succinylcholine Chloride ❏ Quinidin ❏ Warfarin

Other medications ______________________________

Do you drink alcoholic beverages? ❏ NO ❏ YES If yes, how many drinks a day?______

Do you smoke? ❏ NO ❏ YES If yes, how much? ______________________________

Are you currently lactating or are pregnant? ❏ NO ❏ YES

Are you frequently exposed to sunlight, even if you wear sunscreen? ❏ NO ❏ YES

What treatments/medications are you interested in? *(check all that apply)*

❏ Botox/Dysport ❏ Chemical Peel ❏ Dermal Filler ❏ Laser Skin Resurfacing

❏ Foot Detox ❏ Bleaching Cream ❏ IPL ❏ Laser Hair Removal

❏ Dermaplaning ❏ Latisse ❏ Microdermabrasion ❏ Hollywood Laser Peel

❏ Skin Tightening ❏ Body Contouring ❏ Clear + Brilliant ❏ PRP (Platelet Rich Plasma)

❏ BHRT ❏ Facial ❏ Microneedling ❏ Spider Veins/Leg Veins

❏ Thread Lift ❏ Sculptra ❏ Hair Loss ❏ Facial Plastic Surgery

❏ Tattoo Removal ❏ Kybella ❏ Aqua Gold ❏ Rhinoplasty

Printed Name ______________________________

Signature ______________________________ Date ______________

NP Signature ______________________________ Date ______________