What is the main reason for your visit today?

Personal Health #
Patient's Name
Date of Birth
Home Address
City / Postal Code
Phone (cell)
Phone (home)
Email address

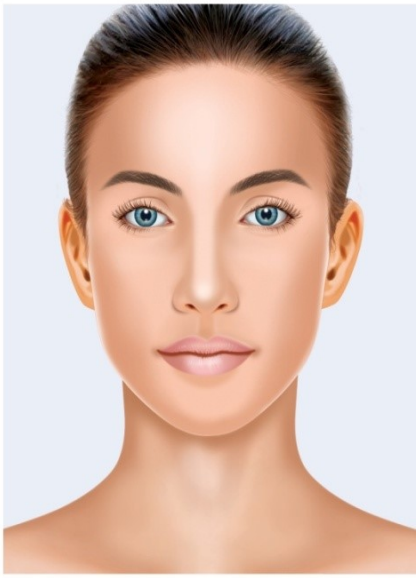
How would you like to be contacted? **CELL HOME PHONE EMAIL**

Would you like to receive our newsletter by email? **YES NO**

Do you consent to us using your photo for before and after pictures on our social media? **YES NO**

Have you had a consult or treatment for a cosmetic procedure before? **YES NO**

Please circle the area(s) that interest you:



Please circle the treatment(s) that interest you:

Skin Care Products	Collagen Production
Facial Filler	Facial Scarring
Anti-wrinkle	Laser Hair Reduction
Laser	Migraine Management
Exfoliation	Excessive Sweating
Sun Damage	Mineral Makeup
Rosacea	Warts/Toe Fungus

Please list all current medications:
(include OTC drugs as well)

Please list all allergies:

_____

_____

_____

_____

_____

Do you have a history of:

Anticoagulant therapy or bleeding tendency?	Yes	No
Epilepsy, strokes or fainting?	Yes	No
Diabetes?	Yes	No
High or low blood pressure?	Yes	No
Infectious Disease (HSV, Hepatitis, HIV etc)?	Yes	No
Are you pregnant or breastfeeding?	Yes	No
Do you plan to become pregnant in the next 2 years?	Yes	No
Have you taken Accutane in the last 6 months?	Yes	No

Emergency Contact: _____ Relationship: _____

Emergency Contact #: _____ Family Physician: _____

Signature: _____ Date: _____

Our clinic thrives on your support. We would love to hear your experience. Would you like to receive a text or email to leave us a Google review?

Yes Email Text No Thank You