Professional Skin Solutions Medical Spa
123 Ohme Garden Rd Ste D, Wenatchee, WA 98801
509.885.4473

PERSONAL INFORMATION

Name: ____ Date of Birth: _________________ Age: ________
First Last

Address: ____
Street City State Zip

Email: ____Phone: ( )________________________________

Occupation ____

Emergency contact _____________________________Emergency Phone ______________________________

CONCERNS OR DESIRED PROCEDURES

What concerns or procedures would you like to discuss, have evaluated and/or treated?

____

PHOTO CONSENT

I consent to the taking of before and after photos to compare my results. I understand that these **will not** be used for any promotional uses without a separate consent. Signature: ___________________________

CANCELLATION POLICY

We request the courtesy of a 24hour advanced notice for rescheduling or cancelling your appointment. If this not honored or occurs repeatedly, we may require advance payment of future appointments. A 'no-show' will result in the inability to schedule future appointments. Thank you for understanding.
Accepted forms of payment are: Visa, Mastercard, Cash, or Checks made out "PSS" we do not accept Amex or Discover at this time.

Signature:______________________________________

RERRERAL INFORMATION

We are so happy you found us! Please take a moment to tell us how you heard about Professional Skin Solutions or let us know who we can thank.

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REWARDS ACCOUNTS

Do you participate in either of these rewards programs?

Aspire (Dysport): www.aspirerewards.com

Alle/Brilliant Distinctions (Botox): www.alle.com
If you do not have either of these accounts, please consider registering prior to your treatments for discounts that can be applied at the time of your visit. Feel free to contact our office if you need help with registration.

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MEDICAL HISTORY

Primary Care Provider: ____

Medications: Are you taking any of the following medication classes?

Antibiotics Yes / No
Oral contraceptives Yes / No
Aspirin/Blood thinners Yes / No

Please list all other medications that you are taking:
____
____

Allergies: Do you have allergies to any of the following?

Latex Yes / No
Aspirin Yes / No
Hydrocortisone Yes / No
Lidocaine Yes / No
Hydroquinone Yes / No

Other drug allergies and reaction (rash, vomiting, etc.): ____

Illnesses, surgeries, and hospitalizations within the past 3 years:
____

List physical activities you participate in regularly:
____

CONDITIONS

Have you ever been treated for, diagnosed as having, or are you currently suffering from any of the following:

- Cancer
- Diabetes
- Seizures
- Thrombosis/embolism
- Collagen, Fat injections
- Cortisone injections
- Multiple Sclerosis
- Rheumatoid Arthritis
- Clotting or Bleeding Disorders
- Hepatitis
- Autoimmune disease
- Hypertension
- Hypoglycemia
- Cardiac History
- Active Infection

Are you pregnant/or breast feeding? ☐Yes ☐No

Do you have a history of perioral herpes/cold sores? ☐Yes ☐No

Have you had any dental procedures in the last 2 weeks? ☐Yes ☐No

Have you ever had past issues with Dysport/Botox or fillers? ☐Yes ☐No

Have you used Accutane in the past 6 months? ☐Yes ☐No

Any additional medical information: ____

I, _________________________, confirm that the above information is true and correct to the best of my knowledge.
Print Name

Signature: ____ **Date:** ____

Reviewed and updated: Signature: _____________________________________ Date:______________________
Reviewed and updated: Signature: _____________________________________ Date:______________________
Reviewed and updated: Signature: _____________________________________ Date:______________________