**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 is not honored or occurs repeatedly it may result in a no-show/Cancellation fee of $50 to the card listed on file. Thank you for understanding. A*ccepted forms of payment are* Visa, Mastercard, Cash, or Checks made out “PSS” we do not accept Amex or Discover at this time.

 Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**APPOINTMENT CONFIRMATION**

How would you like to receive appointment confirmation requests? Please check one.

 **Text Email Telephone Call**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**REWARDS ACCOUNTS**

Do you participate in either of these rewards programs?

**Aspire (Dysport):** [www.aspirerewards.com](http://www.aspirerewards.com)

**Alle (Botox, Latisse and Diamond Glow):** [www.alle.com](http://www.alle.com)

If you do not have either of these accounts, please consider registering prior to your treatment for discounts that can be applied at the time of your visit. Feel free to contact our office if you need help with registration.

**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

Lidocaine Yes / No

Aspirin Yes / No

Hydroquinone Yes / No

Hydrocortisone 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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Patient Reviewed:

Initials\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_ Initials\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_ Initials\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_ Initials\_\_\_\_\_Date\_\_\_\_\_\_\_\_

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