DIAZ PLASTIC SURGERY
breast | body | face | medspa

PATIENT INFORMATION

NAME _____

DATE OF BIRTH_____ AGE_____ SEX_____ SS#_____

ADDRESS_____

CITY_____ STATE_____ ZIP CODE_____

HOME PHONE_____ BUSINESS PHONE _____

CELL PHONE _____ *EMAIL _____

*Providing us with your email will allow us to send you updates on special pricing and promotions. ____Opt in ____Opt out

EMPLOYER _____ OCCUPATION _____

MARITAL STATUS _____ SPOUSES NAME, IF MARRIED _____

EMERGENCY CONTACT _____ CONTACT NUMBER _____

RELATIONSHIP _____

PROCEDURE(S) INTERESTED IN DISCUSSING AT THIS VISIT: _____

We also offer the following services, please check the ones you would be interested in receiving more information about:

- **[ ] Microdermabrasion**
- **[ ] Cosmetic Tattooing**
- **[ ] Botox/Fillers**
- **[ ] Spray Tan**
- **[ ] Skin Care Products**
- **[ ] Endermology/Lipo-Light**
- **[ ] Facials**
- **[ ] Hair Removal**
- **[ ] Waxing**
- **[ ] Make-Up Application**
- **[ ] Laser Resurfacing**
- **[ ] Chemical/Enzyme Peel**

Please check all that apply:

- **[ ] Someone I know has had surgery performed by Dr. Diaz.**
- **[ ] Someone I know has had a treatment/procedure performed by the Vitality Med Spa staff.**
- **[ ] I have visited Dr. Diaz's web site.**
- **[ ] I have seen articles about Dr. Diaz in the newspaper.**
- **[ ] I have heard Dr. Diaz on the radio.**
- **[ ] I have seen/used Dr. Diaz's phone book ad.**
- **[ ] My Doctor referred me to Dr. Diaz and/or Vitality Med Spa.**

SIGNATURE: _____ **DATE:** _____

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CLIENT INTAKE FORM

CLIENT NAME: _____

Are you currently under the care of a physician? YES NO Physician Name: _____

If yes, for what? _____

Are you currently under the care of a Dermatologist? YES NO Dermatologist Name: _____

If yes, for what? _____

Are you pregnant or breastfeeding? YES NO Do you have permanent make-up? YES NO

Do you form thick or raised scars from cuts or burns? YES NO

How would you describe your skin? SENSITIVE NORMAL RESILIENT

Do you have any of the following **medical conditions?** (Please circle all that apply)

CANCER DIABETES HIGH BLOOD PRESSURE HERPES ARTHRITIS FREQUENT COLD SORES HIV/AIDS KELOID SCARRING SKIN DISEASE/SKIN LESIONS HEPATITIS HORMONE IMBALANCE SEIZURE DISORDER THYROID IMBALANCE BLOOD CLOTTING ABNORMALITIES ACTIVE INFECTION

Have you ever had an **allergic reaction** to any of the following? (Please circle)

FOOD LATEX ASPIRIN LIDOCAINE HYDROCORTISONE HYDROQUINONE OTHERS_____

MEDICATIONS:

What oral medications are you presently taking? _____

Are you on any mood-altering or anti-depression medication? _____

What topical creams are you currently using? _____

Have you ever used ACCUTANE? YES NO

I certify that the preceding medical, personal, and skin history statements are true and correct. I understand that I am financially responsible for all charges of services provided to me.

SIGNATURE: _____ DATE: _____

WITNESS: _____