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: _____