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:** ____________________________

CLIENT INTAKE FORM

CLIENT NAME: ________________________________

Are you currently under the care of a physician? YES NO PhysicianName: _________________

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: ____