SKINFINITY MEDICAL
Health - Beauty - Happiness

AESTHETIC CONSENT FORM

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PATIENT INFORMATION

Name:

Date of Birth:

Address:

Home Phone:

City:

State:

Zip:

Cell Phone:

Email:

Occupation:

Emergency Contact:

Emergency Contact Phone:

How did you hear about us?

Referral Source Name:

GENERAL HEALTH/HISTORY

	YES	NO	NOT SURE
Do you have any metal implants, a pacemaker or body piercings?	☐	☐	☐
Do you wear contact lenses?	☐	☐	☐
Do you smoke?	☐	☐	☐
Are you currently pregnant or breast feeding?	☐	☐	☐
Do you have an auto-immune disease? (HIV, Lupus, Hepatitis, other)	☐	☐	☐
Do you have a history of cold sores?	☐	☐	☐
Do you have a history of genital herpes?	☐	☐	☐
Do you have a history of heart condition?	☐	☐	☐
Do you have a history of Diabetes?	☐	☐	☐
Do you have a history of Blood Clots?	☐	☐	☐
Have you or are you currently undergoing Chemotherapy or Radiation treatments?	☐	☐	☐
Have you ever had any facial surgeries?	☐	☐	☐
Have you ever had laser hair removal?	☐	☐	☐
Have you recently been tanning or had sun exposure that changed your skin color?	☐	☐	☐
Have you used any self tanning lotions or treatments?	☐	☐	☐
Are you currently doing any of the following:	☐	☐	☐
Electrolysis?	☐	☐	☐
Tweezing?	☐	☐	☐
Laser Hair Removal?	☐	☐	☐
Waxing?	☐	☐	☐

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MEDICATIONS AND ALLERGIES

	YES	NO	NOT SURE
Do you have allergies to the following			
Aspirin?	☐	☐	☐
Latex?	☐	☐	☐
Hydrocortisone?	☐	☐	☐
Food? (please list)	☐	☐	☐
Wheat/Gluten?	☐	☐	☐
Lidocaine/Novocaine?	☐	☐	☐
Hydroquinone or skin bleaching agents?	☐	☐	☐
Any Botulinum toxin (Botox®) product?	☐	☐	☐
Hypersensitivity to Latisse® (Bimatoprost)?	☐	☐	☐
Any other allergies? (please list)			

Are you currently using:			
Aspirin?	☐	☐	☐
NSAIDS? (Motrin, Aleve, Advil)	☐	☐	☐
Coumadin?	☐	☐	☐
Birth Control Pills?	☐	☐	☐
Hormone Replacement?	☐	☐	☐
Have you ever used Accutane?	☐	☐	☐
Have you ever used RetinA?	☐	☐	☐

SKIN CARE

	YES	NO	NOT SURE
Have you had any of the following:			
Chemical Peel?	☐	☐	☐
Microdermabrasion?	☐	☐	☐
Botox?	☐	☐	☐
Dermal Fillers?	☐	☐	☐
Other resurfacing treatments?	☐	☐	☐
Are you currently using any products that contain:	☐	☐	☐
Glycolic Acid?	☐	☐	☐

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SKIN CARE	YES	NO	NOT SURE
Lactic Acid?	☐	☐	☐
Hydroxy Acid?	☐	☐	☐
Vitamin A?	☐	☐	☐
Do you have any skin sensitivities or conditions? (please list)	☐	☐	☐
Do you have Eczema?	☐	☐	☐
Do you have Psoriasis?	☐	☐	☐

It is my choice to receive elective cosmetic treatment at Skinfinity Medical

I have completed this form to the best of my knowledge. I have stated all medical conditions that I am aware of and I will update my health status.

I acknowledge that these treatments are not a substitute for medical examination or diagnosis, and it is recommended that I see a medical provider or my regular health care provider for that service.

I understand that treatments received at Skinfinity Medical are to be paid in full up front.

I understand that if I am unable to keep a scheduled appointment that I will need to cancel the appointment 24 hours in advance by phone, unless I have an emergency. In this case I will call ASAP to reschedule my appointment. If I miss an appointment without giving 24 hours notice, I agree to pay the missed appointment fee of $100.00 per appointment.

Signature: _____ Date: _____

Print Name: _____

Witness: _____ Date: _____