IMAGE
Skin Institute

CLIENT INFORMATION FORM

Today's Date: ____/____/_____

(Print)
First Name: _____ Middle: _____ Last Name: _____

Date of Birth: _____/_____/_____ Sex: ☐M ☐F ☐T

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Local Address: _____ Apt/Unit/Space#: _____

City: _____ State: _____ ZIP: _____

Home Phone: (_____) _____ Cell Phone: (_____) _____

Summer Address: _____ Apt/Unit/Space#: _____

City: _____ State: _____ ZIP: _____

Home Phone: (_____) _____ Cell Phone: (_____) _____

Would you like to provide us with an email to receive our monthly newsletter and special offers?
☐NO ☐YES your e-mail address: _____

How did you hear about us? _____

Reason for your visit?

☐ Microdermabrasion ☐ Sculptra ☐ Fillers ☐ Chemical Peel

☐ Lamprobe ☐ Botox/Dysport ☐ Deep Pore Treatment

Do you use snore strips? ☐ Yes ☐ No

Please check if you are presently using any of the following:

☐ Retin A/Renova ☐ Glycolic Acid/Alpha Hydroxy Acid ☐ Hydroquinone

Image Skin Institute* 130 South 63rd Street, Bldg 3, Suite 114* Mesa, AZ 85206
(480) 807 1500 Office* (480) 641 4879 Fax

Which conditions do you want improve?

□ Hyperpigmentation (Brown Spots) □ Acne □ Acne Scarring □ Sun Damage

□ Enlarged Pores □ Fine Lines & Wrinkles □ Age Spots □ Surgical Facial Scars

□ Other (Specify) _____

Do you have or have you ever had acne? □ Yes □ No

Have you seen a Dermatologist in the past year? □ Yes □ No

If yes, list the doctor's name and reason for visit _____

_____

Have you ever had Herpes (Cold Sores)? □ Yes □ No

Have you ever been treated with an anti-viral for Herpes? □ Yes □ No

Do you have epilepsy or diabetes? □ Yes □ No

If yes, a doctor's certificate will be required in order for us to treat you.

Are you presently under a physician's care for any reason? Explain: _____

_____

MEDICAL HISTORY:

PLEASE CHECK ANY OF THESE PROBLEMS YOU NOW HAVE OR HAVE HAD:

□ Asthma/Emphysema
□ Hay Fever
□ Eczema
□ Hives
□ Skin Cancer
□ Other Skin Disease
□ Liver Disorder
□ Hepatitis
□ Stomach Ulcer
□ Pace Maker
□ Thyroid disease
□ Diabetes
□ Arthritis
□ Cancer
□ Tuberculosis
□ Stoke
□ Seizures
□ Fainting Spells
□ Headaches
□ Nervous/Emotional Disorder
□ Bleeding Disorder
□ Anemia/Blood Disorder
□ Kidney/Bladder Problem
□ High Blood Pressure
□ Heart Disease
□ Poor Wound Healing
□ Blood Transfusions
□ Eye or Ear Disorder

□ Presently Pregnant □ Menstrual Problems Last Menstrual Period _____

Please list all medications you are taking (including aspirin, birth control pills, laxatives, etc.): _____

Vitamins, herbs, supplements (dosages): _____

Special diet: _____

Are you allergic to any medication, food, clothing, metal, insect, etc.? □ Yes □ No

Please list them: _____

Previous Facial Operations & year:

PERSONAL HISTORY:

Do you or did you:
□ Smoke □ Drink Alcohol □ Work Outdoors □ Work with harmful chemicals
□ Spend a lot of recreational time in the sun (golf, fishing, etc.)

FAMILY HISTORY:

□ Skin Cancer □ Allergies □ Eczema □ Psoriasis □ Hay fever □ Bleeding or clotting disorders

Any other problems or conditions we should know about? _____

Have you had any of the following:
□ Cosmetic Surgery □ Botox Injections □ Skin Cancer □ Dermatitis □ Keloid Scarring
□ Laser Resurfacing □ Chemical Peels □ Hepatitis
□ Other: _____

Do you exercise? □ Yes □ No
Do you wear contact lenses? □ Yes □ No

Have you had skin treatments (facials) before? □ Yes □ No
Have you ever had electrolysis or waxing in the past week? □ Yes □ No
Do you have those services done? □ Yes □ No
Have you had permanent cosmetics? □ Yes □ No
If yes, where? _____

What skin care products are you currently using? _____

What is it about your skin you would like to change? _____

Is there any other information I should know before beginning your treatment? _____

CLIENT PRIVACY INFORMATION

- Federal law states that Image Skin Institute cannot share your health information without your permission except in certain situations. By signing this form, you are giving Image Skin Institute permission to share your health information that is on record with the person(s)/entity you indicate below.
- This authorization is voluntary.
- Image Skin Institute cannot promise that the person(s)/entity you permit Image Skin Institute to share your health information with will not share your health information with someone else whom you may not want to have your health information.
- You can keep a copy of this authorization, or contact Image Skin Institute to get a copy if you need one.
- This authorization requires yearly updates.

I give permission to Image Skin Institute to use the name(s) listed below as my emergency contact and/or to share my health information with via telephone or in person:

Name: _____ **Relationship:** _____ **Phone: (____)** _____

***A copy of the Notice of Privacy Practices* is available upon your request.**
Please check your preference.

☐**YES** ***I would like a copy*** ☐**NO** ***I do not want a copy***

Print name: _____ **Signature:** _____

If you are the Parent/Legal Guardian completing this paperwork for a patient who is *a minor*; please print and sign name below:

Print name: _____ **Signature:** _____