SPINE & EXTREMITIES CENTER

Today's Date: _____ Referred by: _____

Patient Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cellphone: _____

Date of Birth: _____ Age: _____ Occupation: _____

Emergency Contact: _____ Phone: _____ Relationship: _____

Do you have any allergies or sensitivities? □ Yes □ No If yes, please list: _____

_____

Are you currently taking any medications? □ Yes □ No If yes, please list: _____

_____

_____

Are you currently taking any aspirin, ibuprofen, minerals, herbs or nutritional supplements? □ Yes □ No

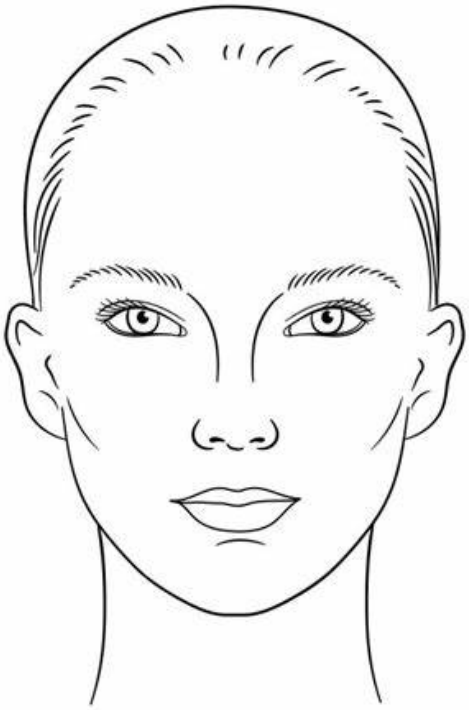
If yes, please list: _____

Women only: Are you pregnant, nursing, or planning a pregnancy? □ Yes □ No

Have you experienced any of the following?

High or Low Blood Pressure	□ Yes	□ No	Hormone Replacement Therapy	□ Yes	□ No
Seizures/Epilepsy	□ Yes	□ No	Thrombophlebitis	□ Yes	□ No
Stroke	□ Yes	□ No	Deep vein thrombosis	□ Yes	□ No
Hepatitis	□ Yes	□ No	Autoimmune disease	□ Yes	□ No
Easily Bruise	□ Yes	□ No	Hemophilia/bleeding disorder	□ Yes	□ No
Migraine headaches	□ Yes	□ No	Rheumatoid arthritis	□ Yes	□ No
Cancer	□ Yes	□ No	Osteoporosis	□ Yes	□ No
Circulatory problems	□ Yes	□ No	Aneurysm	□ Yes	□ No
Tumors or cysts	□ Yes	□ No	Blood clots	□ Yes	□ No
Diabetes	□ Yes	□ No	Complex regional pain syndrome	□ Yes	□ No
Dark spots after pregnancy	□ Yes	□ No	Keloid scars	□ Yes	□ No
Hyperpigmentation	□ Yes	□ No	Hypopigmentation	□ Yes	□ No
Scleroderma	□ Yes	□ No	Cataracts / dry eye	□ Yes	□ No
Treatment with Accutane	□ Yes	□ No	HIV / AIDS	□ Yes	□ No
Fainting or dizzy spells	□ Yes	□ No	Other: _____		

Surgical history: _____



What type of skin do you have?
□ Normal □ Dry □ Oily □ Combination

What areas of concern do you have regarding your skin?

□ Breakouts/Acne	□ Blackheads/Whiteheads	□ Sun Damage
□ Uneven skin tone	□ Wrinkles/Fine lines	□ Dull/Dry skin
□ Hyperpigmentation	□ Broken Capillaries	□ Rosacea

Other: _____

Do you currently or have you used in the last 3 months: Retin-A, Renova, AHA's or Retinol/Vitamin A derivate products? □ Yes □ No If yes, please list: _____

Have you received Botox, Dysport, Restylane, or other injections in the last 6 months? □ Yes □ No If yes, please specify: _____

_____

Cancellation Policy: 24-hour notice is required when cancelling an appointment. This allows the opportunity for someone else to schedule an appointment. Appointments cancelled less than 24-hour notice are subject to a 50% fee of the service(s) booked. If you no call/no show, you will be charged 100% of the service(s) booked.

Late Arrival Policy: If you arrive late, your session will be shortened to accommodate appointments that follow yours. Regardless of the length of the treatment, the session will be charged in full. If you are more than 10 minutes late to your appointment you will be rescheduled at the providers discretion and will be subject to a fee of 50% of the service(s) booked.

Patient Consent/Liability Waiver: Facials/Chemical Peels should not be performed under certain medical conditions. The information that I provided is accurate and complete. I agree to keep Spine & Extremities Center informed of any changes in my medical profile and understand that there shall be no liability on Spine & Extremities Centers' part should I fail to do so. The services I am scheduled for require person-to-person contact. By signing below, I am acknowledging this and giving permission to be treated at Spine & Extremities Center, PC. Spine & Extremities Center is not responsible for any items that you may leave unattended. We strongly recommend leaving expensive, personal items at home, or locked in your car. If you do bring them with you, be sure to gather all items from the treatment room prior to leaving.

Patient Signature: _____ **Date:** _____

Provider Signature: _____ **Date:** _____