ARC AESTHETICS

CLIENT INTAKE FORM

THIS FORM MUST BE COMPLETED IN FULL & RETURNED PRIOR TO THE SCHEDULING OF YOUR APPOINTMENT.

First Name : Last Name :

Date of Birth : Gender : Male Female

Address :

Phone Number : Email :

Health Card Number

How I heard about Medical Aesthetics of

Skin Care Product List (complete table):

Wash:	Moisturizer:
Retinol:	SPF:
Others: (please list)	

My skin is (check appropriate box):

Oily	Dry	Combo	Acne Prone

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Arcaestheticsinc@gmail.com

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Please complete both pages. 2/3 Pages

Medical history (complete table):

Bleeding disorder	Clotting disorder	Keloid scars
Connective tissue disorder	Myasthenia gravis	ALS
Lambert-Eaton syndrome	Parkinson's disease	Tanning bed use
Skin cancer	Eczema	Psoriasis
Eye concerns	Diabetes	Smoker
Breastfeeding	Currently are or are trying to get pregnant	
Cold sores/herpes simplex virus (if yes, where?):		

List any aesthetic/cosmetic medicine procedures you have had in the past:

Any other relevant medical history:

List of medications/supplements:

Accutane (if yes, when last used?):
Antibiotics (if yes, which ones and when last used?):
Blood thinners (if yes, please list):
Anti-inflammatories (if yes, please list):
Retin A
Vitamin E
Others (please list):

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Please complete both pages. 3/3 Pages

Allergies (complete table):

Sulpha	Iodine	Lidocaine
Skin bleaching agents	Hydroquinone	Aspirin
Animal protein	Adhesive tap	Latex
Others: (please list)		

Please indicate which treatments you would like to know more about?

Botox/Dysport/neuromodulators	Fillers/Hyaluronic acid	Improving acne
Improving skin texture	Reducing leg veins	Reducing wrinkles
Microneedling	Reducing facial veins	Improving skin laxity
Reducing brown spots	Laser hair removal	Moles, bumps and skin tags
Others: (please list)		

Review the following clinic policy forms and consents and initial below as appropriate. Copies of these forms can also be sent to you by email or regular mail upon request.

At Medical Aesthetics of (Insert name here), we value your privacy and prioritize compliance with Canada's anti-spam legislation and the Personal Health Information Protection Act. Email is used for appointment reminders, sales receipts, upcoming promotions (maximum of 4 emails/year), and information regarding new products and services.

The use of the photographs is for documenting medical conditions, illustrating medical procedures and the demonstration of treatment outcomes. Photographs will be kept securely in an Electronic Medical Record. Any digital copies of photographs that have been forwarded to (insert company name) will be entered securely into the EMR and the communication will be permanently destroyed.

_____ *I have read, understand, and accept the Clinic Policies (initials required)*
_____ *I have read, understand, and accept the Virtual Care Policies (initials required)*
_____ *I have read, understand, and accept the Photography Consent Policy (initials required)*
_____ *I have read, understand, and accept the Email Consent Policy (initials required)*

I understand the aesthetic medicine treatments and services are not covered by insurance (OHIP or private), and that I am fully responsible for the costs associated with these treatments and services.

Signature: _____Date (dd/mm/yyyy):_____