

**Cosmetic Procedure Patient Registration**

First Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Middle Initial: \_\_\_\_\_ Last Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_ Age: \_\_\_\_\_\_ Gender: Male\_\_\_ Female\_\_\_ Transgender\_\_\_\_

Street Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_\_\_\_ Zip Code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone Provider: ATT\_\_ Verizon\_\_ T-Mobile\_\_ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How did you hear about us? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Would you like to receive appointment reminders via text? (please circle) YES NO

Would you like to receive monthly specials via email? (please circle) YES NO

Primary reason for consultation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**“Images” Authorization (Non-optional)**

I hereby authorize Beauty Camp Aesthetics/Nicole Camp to take “Images” (including but not limited to: photographs, videotape or digital images) of me so that my treatment results and progress will be monitored and reviewed accurately. I understand that these “Images” are confidential and Beauty Camp Aesthetics/Nicole Camp, its affiliates, successors and assignees will not use my “Images” except as permitted on this authorization form and I hereby release Beauty Camp Aesthetics/Nicole Camp from any claim demand, cause, action, or proceeding of whatever nature arising of the said “Images” in accordance with the terms of this release.

By signing this authorization, I acknowledge that I have read and understand the statements contained herein. I understand that I will be given a signed copy of this form upon my request.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_

Print Name Signature Date

**Optional “Images” Release**

By initialing below, I hereby authorize Beauty Camp Aesthetics/Nicole Camp, its affiliates, successors and assignees to use and release my “Images” to the general public for the following purposes:

1) \_\_\_\_\_ Educational lectures, presentations, journals and textbooks for health care professionals.

2) \_\_\_\_\_ Patient education materials (website, brochures, before & after book, T.V. loop, etc.).

3) \_\_\_\_\_ General advertising, marketing, publicity or promotional purposes (testimonials, social media, etc.)

By signing this optional release, I understand this authorization is voluntary and I can revoke my authorization by submitting a letter in writing to Beauty Camp Aesthetics/Nicole Camp stating that I revoke my authorization of the optional releases. Beauty Camp Aesthetics/Nicole Camp will not disclose any more “Images” of me after receipt of the letter.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Name Signature Date

**Health History Form**

**PATIENT MEDICAL HISTORY** (please check the following if apply)

 \_\_\_\_**CARDIOVASCULAR** (heart attack, stroke, chest pain, valve disease) \_\_\_\_**RESPIRATORY** (emphysema, asthma, tuberculosis) \_\_\_\_**ENDOCRINE** (diabetes, thyroid) \_\_\_\_**VIRAL** (fever blisters, herpes) \_\_\_\_**INTEGUMENTARY** (psoriasis, eczema) \_\_\_\_**HEMATOLOGIC** (anemia, bleeding tendency) \_\_\_\_**EYES** (glaucoma, cataract) \_\_\_\_**NEUROLOGICAL** (seizures, numbness, tremors)

**OTHER PREVIOUS DIAGNOSIS:** (e.g. high cholesterol or blood pressure, cancer) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Last Menstrual Period: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Current Prescription Medications & Dosage** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Have you ever taken Accutane? **Y** or **N** If so, when? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Allergies** (please check the following if apply) \_\_Cow’s Milk \_\_Botox \_\_Lidocaine \_\_Tetracaine

**Other Allergies \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Previous Operations & Dates** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Previous Cosmetic Procedures/ Surgeries & Dates** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**SOCIAL HISTORY**

Do you smoke cigarettes \_\_\_**Y** \_\_\_**N** Do you drink alcohol? \_\_\_**Y** \_\_\_**N**

**What is your home skincare routine? Please include brand names.**

 **AM PM**

Cleanser \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Toner \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Topical (Retin-A, Glycolic, Vit. C) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Moisturizer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Eyes \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Sunscreen \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Exfoliant, Mask \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Have you experienced any of the following?** (please check all that apply)

**Face/skin**

Puffy Eyes\_\_\_ Dark circles\_\_\_ Pigmentation\_\_\_ Fine Lines\_\_\_ Unwanted Hair\_\_\_ Sagging Skin\_\_\_ Uneven Skin Tone\_\_\_ Uneven Texture\_\_\_ Large Pores\_\_\_ Scars\_\_\_ Dryness\_\_\_ Oiliness\_\_\_ Sensitivity\_\_\_ Rosacea\_\_\_ Broken Capillaries\_\_\_ Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Body**

Cellulite\_\_\_ Spider Veins\_\_\_ Unwanted Hair\_\_\_ Unwanted Fat\_\_\_ Loose Skin\_\_\_ Stretch Marks\_\_\_ Scars\_\_\_ Pigmentation\_\_\_ Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Check Yes or No: YES NO YES NO**

Have you had a chemical peel? \_\_\_ \_\_\_ Have you had Botox or fillers? \_\_\_ \_\_\_

Have you had laser treatments? \_\_\_ \_\_\_ Do you exercise regularly? \_\_\_ \_\_\_

Are you on a restricted diet? \_\_\_ \_\_\_ Do you have a pacemaker? \_\_\_ \_\_\_

Do you wear contacts? \_\_\_ \_\_\_ Do you have metal implants? \_\_\_ \_\_\_

I confirm to the best of my knowledge that the answers I have given are correct and that I have not withheld any information that may be relevant to my treatment today.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Signature/Legal Guardian Signature Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Witness Signature Date

**Cancelation Policy**

Here at Beauty Camp Aesthetics patients are the most important part of our practice. This cancellation policy has been put in place for our patients. Our appointments are reserved just for you. Related to this, we want you to understand that it is also a potential appointment for someone else who may have wanted it at that particular time.

As a courtesy to our providers and to other patients, we ask that you provide our office with **a minimum of 24 hours’ notice should you need to cancel or reschedule your appointment**. If an appointment is canceled or rescheduled within 24 hours of appt time, or a no-show, you will be assessed a **$50 cancellation fee.**

If you arrive to your appointment more than 15 minutes past the originally scheduled time, we may require you to reschedule to avoid impacting other clients’ appointments.

**REFUND POLICY**

**Refunds are not given on services rendered due to the nature of medical aesthetic treatments. All other refunds will be as Spa credit only.** Aesthetic results are variable from person to person and while we do our best to achieve the desired outcome it cannot always be guaranteed. Clients are responsible for further treatments needed to achieve further results.

**PRODUCTS**

We do not offer refunds on products purchased. Products may be returned for in-spa credit within 7 days from the date of purchase when there is a documented adverse reaction to the product. Defective products (i.e., a broken pump) may be exchanged within 7 days for the same product only.

Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Witness Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_