PATIENT INFORMATION-MEDICAL HISTORY RECORD

Name:_____**Date:**_____ **Age:**_____

Address:_____ **City:**_____ **State:** _____ **Zip Code:**_____

Home Phone:_____ **Work:**_____ **Cellular:**_____

Date of Birth:_____(Month)_____(Day)_____(Year)

Marital Status: ____Single ____Married____Divorced____Widow

Employer:_____**Occupation:**_____

Name of Emergency Contact:_____ **Relationship:**_____

Emergency Contact: Home Phone:_____Work Phone:_____ Cellular:_____

What is your email address:_____@_____.com

I would like to be contacted by email for SKINfinity LLC's ____Special Offers In Newsletter____Invitations.

I am a BRILLIANT DISTINCTIONS *Reward* Member:_____Yes_____No

I was referred to SKINfinity by: _____*Thank you for letting us know!*

MEDICAL AND HEALTH HISTORY

Medications: Important, please list ALL prescriptions, over the counter medications, vitamins or herbal medications that you are currently taking or have taken within the last **30-60-90** days:_____

Surgeries:

Surgery:_____ Date:_____ Surgery:_____Date:_____

Surgery:_____Date:_____ Surgery:_____Date:_____

Any additional information_____

Have you received a NON-SURGICAL cosmetic procedure in the past 30 to 90 days? (Such as Botox, fillers?) ____Yes ____No (IF YES, How long ago?) _____. What procedure (s) did you have?_____.

Allergies: Please list any known allergies here:_____,_____,_____,_____

MEDICAL AND HEALTH HISTORY *Continued*

Please read and check (√) all conditions that apply

___Heart Disease or Stroke
___Excessive Bleeding or Bruising
___Anticoagulants or Blood Thinners
___Blood Problems (Sickle cell anemia, Hemophilia)
___Diabetes
___High Blood Pressure
___Blood Clots
___Glaucoma
___Mental Disease
___Auto-immune Disorders
___Liver Disease
___Neuro-muscular Disease, History of Seizures
___Cold Sores/Fever Blisters
___Cancer, Chemotherapy or Radiation therapy
___Skin Cancer
___Alcoholism/Drug Abuse
___Pregnant, or trying to become Pregnant
___Breastfeeding
___Smoker, Packs per day _____
___Mild, Moderate, or Excessive Alcohol consumption- circle
___Other (Please describe)

_____
_____
_____

___NONE

ACKNOWLEDGEMENT OF MEDICAL HISTORY

I, (patient) have provided the above information to **SKINfinity, LLC** that is true and acurate to the best of my knowledge. I understand the importance of providing any updates to my medical history that could be of concern, and agree to notify **Mary Nissen, RN BSN** prior to my treatment.

_____ _____
Patient Signature **Date**

ACKNOWLEDGEMENT OF CANCELLATION POLICY

Our Cancellation Policy requires a **24-HOUR NOTICE** to cancel or reschedule your appointment. A **$75 Cancellation Fee** will be assessed by our office for a "no show" or failure to comply with our Cancellation Policy. **SKINfinity, LLC** reserves the right to request a non-refundable deposit of $75 as a confirmation of your appointment with a history of cancellation requests. A *Deposit is only CREDITED IN FULL towards the services received on the date we have *secured your appointment time; or forfeited entirely at the discretion of our office.

_____ _____
Patient Signature or Parent/Guardian **Date**