RIOS HEALTH & BEAUTY
ENHANCING BEAUTY, NOURISHING HEALTH

CONSULTATION FORM

Name : _____ Date : _____

Date of birth : _____ Age : _____ ☐Male ☐Female ☐ Non-Binary

Address: _____

City: _____State : _____ Zip Code : _____

Phone:_____ Email : _____

Emergency Contact: _____ Phone Number: _____

How did you hear about us?_____

Are you referred by someone? If so, whom?_____

Would you like to be added to our email list for news and exclusive offers? _____

MEDICAL HISTORY

Please mark any of the following conditions you may currently have

☐ High Blood Pressure
☐ Breastfeeding
☐ Bleeding Disorders
☐ Diabetes
☐ Thyroid Disorder
☐ Fillers/Botox
☐ Hepatitis
☐ Pregnancy
☐ Seizures
☐ P a n c r e a t i t i s
☐ Alcohol Use Disorder
☐ Illicit Drug User
☐ Past addiction disorder
☐ Other _____
☐ Recent Gastric Surgery
☐ Birth Control

Any other conditions? _____

If you ticked any boxes, please give further details _____

_____

Do you have any allergies? ☐ Yes ☐ No

If so, please list all _____

List all medications you take, including vitamins, herbal supplements, aspirin, hormones, and topical

_____

_____

Are you currently pregnant or trying to get pregnant? ☐ Yes ☐ No

Do you smoke? ☐ Yes ☐ No

Do you consume alcohol? ☐ Yes ☐ No

WHAT'S THE REASON FOR THE VISIT?

_____

_____

_____

<u>By signing below, you agree to the following:</u>

I have completed this form truthfully and to the best of my knowledge. I agree to waive all liabilities toward my medical members and the employer for any injury or damages incurred due to any falsification of my medical history

_____ _____

Patient Name (Printed) **Patient Signature**

_____

DATE :

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PATIENT TREATMENT RECORD

Name : _____ Date : _____

Date of birth : _____ Age : _____ ☐Male ☐Female ☐ Non-Binary

Address: _____

City: _____State : _____ Zip Code : _____

Phone:_____ Email : _____

Clinical Note :

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

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CANCELATION POLICY

To ensure high-quality care within a reasonable timeframe, we have implemented an appointment and cancellation policy.

As appointments are in high demand, canceling your appointment in advance allows us to offer the time slot to another individual seeking timely care. This policy helps us optimize our appointment availability for all clients.

During the appointment booking process, you must make a $50 deposit, which will be applied as a credit towards your scheduled treatments.

We understand that circumstances may arise requiring you to cancel or reschedule your appointment. To avoid any inconvenience, please notify us at least 72 hours before your scheduled appointment. In such cases, your deposit will either be refunded or applied towards a future appointment. However, if you provide less than 72 hours notice, a $50 cancellation fee will be charged.

Please note that if you arrive more than 20 minutes late for your appointment, it will be considered a no-show, and the cancellation fee will be applied.

We are more than happy to address any inquiries or concerns you may have regarding our cancellation policy.

I have read and fully understand the above Appointment Cancellation Policy and agree to be bound by its terms. I agree to pay the cancellation fee in the event of a missed appointment.

_____	_____	_____
Patient Name (Printed)	Patient (signature)	Date