ESTHETIC BOUTIQUE MED SPA.

Patient Intake Form

Name: _____
Date of Birth:_____ Age: _____
Address:_____
City: State: Zip: _____
Phone: _____
Email: _____

How did you hear about us? _____

Employer: _____

Emergency Contact Name and number:_____
Relationship: _____

ALLERGIES:_____

Medical History:_____

List ALL current medications including aspirin, ibuprofen, herbal remedies, blood thinners, fish oils, etc.
_____

Primary Healthcare Provider:_____

Do we have permission to contact you for appointments/ promotions via Phone and Email?
Yes / No

Please Mark any Current Conditions and/or Previously Experienced:
_____ Allergies to medications, food, latex, topical products or other substances.
If YES, Please List:_____
_____ Skin Infections
_____ Antibiotics
_____ Seizure history
_____ Pregnancy/Nursing
_____ Herpes or cold sores

Please Answer the Following Questions:
Which concerns apply to you? (Check all that apply):
□ Upper Lip Lines
□ Wrinkles
□ Other: _____

Have you ever had any of the following injectables:
Botox Xeomin Jeuveau Juvederm Radiesse Restylane Perlane Silicone Hylaform
Collagen Bellafill Sculptra Dysport Other: _____
*If so, date of last treatment? _____
What area? _____
Have you had any other cosmetic surgeries/procedures? Yes / No
When? _____
Were you pleased with the results?
_____

Please Mark any Services You Would Like to be Educated On:
___ Injectables (Botox, fillers, etc.)
___ Lip Augmentation

Thank you for taking the time to complete our Patient Intake form. With the following information, we will be better able to serve you. Our goal is to provide you with excellent service and results. At future visits, please let us know if any of the previous information changes. All information and treatments are confidential.

Cancellation Policy
It would be greatly appreciated if appointments need to be cancelled, rescheduled, or the appointment type changed, that it be done at least 24 hours in advance. Should you fail to give us 24 hours' notice to cancel or alter your appointment; a cancelation fee of $25 WILL be charged to the credit card on file OR a deposit for the full cost of future services will be required at the time of booking.
Initial that you have read and agree: _____.

Payment Policy

We are committed to the success of your medical treatment and care. Please understand that payment for your services is part of your treatment and care. You are responsible for the FULL payment the time of service. Initial that you have read and agree: _____.
I understand that the results are not guaranteed. There are many variables that are beyond our control that affect the procedure outcomes, especially individual expectations. We maintain our equipment and continue staff education and training regarding technique. There are times when the human body does not respond as well as we would like. Lifestyle choices, diet, exercise, hydration, prior skin damage, sun exposure and many other factors affect the final results. All clients are unique and have unique needs and expectations. Please discuss your treatment expectations with us prior to your treatment because there are NO refunds.

Initial that you have read and agree: _____.

Patient/Representative Signature: _____ Date: _____

Provider/Office Representative Signature: _____ Date: _____