PATIENT INTAKE FORM

NAME: _____

DATE OF BIRTH: _____

ADDRESS: _____

PHONE NUMBER: _____

EMAIL ADDRESS_____

EMERGENCY CONTACT: _____

ALLERGIES: _____

ARE YOU PREGNANT OR NURSING: ☐ YES ☐ NO

PAST MEDICAL HISTORY:

_____

_____

_____

CURRENT MEDICATIONS:

_____

_____

_____

YOUR CONCERNS – WHAT AREAS WOULD YOU LIKE TO GET TREATED?

_____

_____

_____

PAST COSMETIC SURGERIES/PROCEDURES

_____

_____

_____

DO YOU SMOKE / VAPE? ☐ YES / ☐ NO

IF YES, HOW MUCH or HOW OFTEN? _____

Reviewed by Staff.

NAME_____SIGNATURE_____DATE_____