Forever Flawless Medical Aesthetics and Laser LLC

CLIENT INFORMATION & MEDICAL HISTORY

PERSONAL HISTORY

Client Name_____ Today's Date_____

Date of Birth _____ Age _____ Occupation _____

Home Address _____ City_____ State ____Zip Code _____

Cell Phone _____Email_____

Emergency Contact Name and Phone_____

How were you referred to us? _____

Do you regularly sun bathe or use tanning salons? _____How often? _____

MEDICAL HISTORY

Are you currently under the care of a physician? ☐Yes ☐ No

If yes, for what:

_____

_____

Do you have any of the following medical conditions? (Please check all that apply)

❑Cancer ❑Diabetes ❑High blood pressure ❑Herpes ❑Arthritis ❑Frequent cold sores

❑HIV/AIDS ❑Keloid scarring ❑Skin disease/Skin lesions ❑Seizure disorder ❑Hepatitis

❑Hormone imbalance ❑Thyroid imbalance ❑Blood clotting abnormalities ❑Any active infection

Do you have any other health problems or medical conditions? Please list: _____

_____

Have you ever had an allergic reaction? (List any and all that you have had and describe the reaction you experienced) ❑Food ❑Animal Protein ❑Aspirin ❑Lidocaine ❑Hydrocortisone ❑Hydroquinone or skin bleaching agents

❑Others**:** _____

MEDICATIONS

What oral prescription medications are you currently taking? ❑Birth control pills ❑Hormones

❑Others (It is required that you list all of them): _____

_____

Are you currently or recently taking any antibiotics? _____

What topical medications or creams are you currently using? ❑ RetinA ❑ Retinol ❑ Renova

❑ Tretinoin ❑Others (Please list): _____

Are you currently or recently using: ❑ Accutane ❑ Isotretinoin ❑ Bactrim ❑ Proactive ❑ Epiduo

❑ Differin ❑ Doxycycline ❑ AHA/BHA ❑ Hydroquinone ❑ Tazorac

What herbal supplements do you use regularly? _____

HISTORY

For our female clients:

Are you pregnant or trying to become pregnant? ❑Yes ❑No Are you breastfeeding? ❑Yes ❑No

Are you using contraception? ❑Yes ❑No

I certify that the preceding patient medical history statements are true and correct. I am aware that it is my responsibility to inform the performing practitioner of my current medical or health conditions and to update this history. A current and accurate medical history is essential for patient safety during all treatments.

Signature _____ Date _____

NO SHOW/LATE POLICY

We strive to provide excellent and timely customer service for all of our clientele, and to do so, we require all cancellations and reschedules to be completed at least 24 hours before a scheduled appointment. A $25 fee will be applied to client accounts for no show appointments 30 minutes or less, and a $45 fee will be applied to clients for no show appointments 45 minutes or longer.
In order to provide consistent, high quality results, clients arriving more than 10 minutes late to an appointment will need to be rescheduled for another time. Arriving more than 10 minutes late without calling will be considered a No Show appointment and the client account will be assessed the appropriate fee. Rescheduling will not be permitted until fee has been paid and account is current.

I have read and agree to the No Show/Late Policy.

Signature _____ Date _____