Patient Name:____Date of Birth: ________________

Please provide your medical history:

Drug Allergies:____

____

Current medications including supplements:____

____

____

List any current or past medical problems, major surgeries, including previous cosmetic procedures, or other significant medical issues and approximate dates:

____

____

____

____

In accordance to new rules adopted by the Texas Medical Board (S193.17) effective November 7, 2013 regarding the delegation of nonsurgical cosmetic procedures for all medical practices in Texas. I agree to be evaluated by a Physician or Physician's Assistant for the approval of the following treatments:

Patient Signature:

____Date:____________________

FOR OFFICE USE ONLY:

Injected Neurotoxins________________ Injected Fillers________________Laser Treatments___________

Chemical Peels______________ Radio Frequency Treatments _______________ Photofacial ____________

Platelet Rich Plasma________________ Tattoo Removal_________________ Other _________________

Approved:_________________ Not Approved:__________________ Topical Anesthetics:______________

Special Instructions:____

Orders are good for one year from today's date.

Physician or Physician's Assistant Signature:__________________________________ Date: ___________

Renewal required on: ____