aesthetica
med spa
ADVANCED COSMETIC DERMATOLOGY

Patient Information Sheet

Patient Name:_____ Marital Status:_____# of Children:_____
Address:_____ City:_____ State:_____ZIP_____
Phone:_____ Date of Birth:_____ Email:_____
Gender:_____ Height:_____ Weight:_____ Occupation:_____
Emergency Contact:_____Phone: _____
How did you hear about us?_____

Please Circle Your Interests: BOTOX | COSMETIC FILLERS | SKIN TIGHTENING | FACIALS | BROWN AGE SPOTS | PHOTOFACIALS | CHEMICAL PEELS | SKIN CARE PRODUCTS | STRETCH MARKS | LIPOSUCTION | LEG VEINS | SUN DAMAGE | THREADLIFT | PRP STEMGLO | MICRONEEDLING | FRACTIONAL RESURFACING

Have you ever used: RETINOIDS ACCUTANE HYDROQUINONE TAZORAC FAMVIR
What is your current skincare routine? _____
_____
Do you use sunscreen?_____ **If so, what kind?**_____
Circle any that apply to your skin: dry oily normal acne freckles rosacea rednessflakiness combination fine lines sun damage brown spots broken capillaries
Are you pregnant or planning to get pregnant?_____
Do you smoke?_____ **If so, how many packs per day?**_____
Do you take replacement hormones?_____
Have you taken steroids or cortisone in the last year?_____
Do you take aspirin regularly? How many daily? _____
Have you ever been diagnosed with: dizziness fainting spells nervousness/anxiety
Have you ever had problems with: heart disease blood clotting or excessive bleeding diabetes high blood pressure HIV/AIDS lung problems

ALL OF THE ABOVE INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE.

PATIENT SIGNATURE:_____ **DATE:**_____

ASSIGNMENT AUTHORIZATION

By signing below, you agree to and understand the following policies of Aesthetica MedSpa:

- I authorize the associates of Aesthetica MedSpa/Austin Family Medicine to administer medical treatment, as they deem necessary. I understand that there will be a 50% charge of service for appointments not cancelled 24 hours in advance. I understand that I am financially responsible for any balance incurred at the time of this service.

ASSIGNMENT OF LEGAL RIGHTS

- If payment is not received within 30 days after services are rendered, i irrevocably assign my legal rights so that Aesthetica Medspa/Austin Family Medicine Associates may pursue collection of payment for all services provided.

PATIENT SIGNATURE: _____ **DATE:**_____

ACKNOWLEDGMENT OF REVIEW OF NOTICE OF PRIVACY PRACTICES: I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

PATIENT SIGNATURE:_____**DATE:**_____