NEW PATIENT INFORMATION

Today's Date: ___/___/______

Last Name: ________________________ First Name: ______________________________DOB: ___/____/_______
Address: ____City: ________________ State: ________ Zip: __________

Phone number to contact you regarding treatment, to leave a message and appointment reminders:
Cell Phone: (____) ___________ Email (for reminders and monthly specials): ______________________________
How did you hear about us? ______________________________ May we thank them for referring you? Yes/No
Emergency Contact: ____ Phone: (____)_______________
Primary Care Physician: ____ Phone: (____)_______________

Please answer YES or NO to the following:

YES NO Are you using any prescribed medications? List: ____
YES NO Are you using any allergy, cold or sleeping medications? List: ______________________________
YES NO Are you using any herbal supplements? List: ____
YES NO Do you take anti-coagulant (blood thinning) medication? List: ______________________________
YES NO Are you allergic to any cosmetic ingredients, medications, topical anesthetics, lidocaine, latex, chlorhexidine, gram-positive bacterial proteins, phenylephrine bee stings or foods?
List: ____
YES NO Do you have a history of multiple severe allergies or anaphylaxis?
YES NO Are you pregnant, trying to become pregnant or breastfeeding? ______________________________
YES NO Do you smoke? How much? ____________ How long? ____________
YES NO Do you spend a lot of time outdoors or use a tanning bed often?
YES NO Do you have any tattoos or permanent makeup? Where? ____________________________________

Please check any chronic skin disorders, or check NONE

Cold sores	Fever or sun blisters	Dermatitis	Skin infections
Psoriasis	Eczema	Rosacea	Herpes Simplex/blisters
Excessive scarring	Keloid scarring	Cystic acne	Pigmentation disorder

Other: _________________________________

Please check any health problems, past or present, or check NONE

Seizures	Hormonal problems	Neuro-Muscular disease or disorder
High blood pressure	Cardiovascular disease	Hepatitis/HIV/AIDS
Asthma or pulmonary issues	Emphysema	Difficulty breathing or swallowing
Vasovagal syncope	Liver disease	Diabetes
PCOS	Kidney disease	Collagen disorder
Thyroid disease	Sarcoidosis	Autoimmune disease
Immunosuppression	Blood disease	Clotting or bleeding disorder
Eye or vision problems		

Cancer/Skin Cancer - Type:________________ Location: __________________ When treated: ______________
Other: _________________________________

What is your skin type: Dry Combination Normal Oily

Please tell us your main concerns that brought you to our office today: _________________________________

____

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Have you ever had any of the following injectables, fillers or implants? or check NONE

Botox, Dysport, Xeomin, Jeuveau or other botulinum toxin?

What? ______________When? ______________ What areas? ____

Juvéderm, Restylane, Sculptra or other dermal filler?

What? ______________When? ______________ What areas? ____

Have you ever undergone any of the following skin treatments? or check NONE

Chemical peel | Microneedling | Skin resurfacing or fractional laser

Facial surgery | Lasers | Accutane | Cosmetic surgery

Other: _________________________________

What? ______________When? ______________ What areas? ____

Which conditions concern you the most:

Wrinkles | Uneven skin tone | Brown spots, sun spots, freckles

Sun Damage | Upper lip lines | Visible veins or blood vessels

Enlarged pores | Scarring | Excessive oiliness

Melasma | Blackheads/Whiteheads | Dry patches

Acne/Pimples | Hard bumps under skin | White spots (Hypopigmentation)

Facial redness | Rosacea | Sparse or short eyelashes

Unwanted hair | Other: ____

Please list the products you currently use and list the brand names of the products:

Cleanser ______________________________ | Toner _________________________________

Moisturizer ____________________________ | Sunscreen/SPF __________________________

Eye cream ___________________________ | Vitamin C product _______________________

Retinol/Retin-A__________________________ | Skin lightening product ___________________

AHA/BHA product _______________________ | Lash product ___________________________

Acne product ___________________________ | Other _________________________________

Are you using any prescription topical products or oral antibiotics for acne, skin cancer, anti-aging or hyperpigmentation? List: ____

Are you currently removing hair by any of the following methods?

Waxing | Tweezing | "Nair" type products

Electrolysis | Laser hair removal: When? _________ What areas? _______________________

REQUIRED FOR SKIN ANALYSIS & TREATMENT
Your Ethnicity:
Mother's Ethnicity: Father's Ethnicity:
Are you tan? _____ Do you tan artificially?_____ Tanning Bed? _____ Spray-on Tan? _____
When was the last time you had a significant amount of sun exposure?

HIPAA Acknowledgement: I have been informed by Southwest Contemporary Women's Care of the HIPAA law regarding privacy practices and procedures and have been offered a copy of its HIPAA policies.

I certify that the above information is correct to the best of my knowledge.

_____________________________ _________________________________ ______________

Patient Signature *Print Name* *Date*

Southwest Contemporary Women's Care Notes: ____

SKIN TYPE ANALYSIS
(for laser procedures and facial treatments)

Score	Analysis	0	1	2	3	4
	What is the color of your Eyes?	Light Blue, Gray or Green	Blue, Gray or Green	Hazel or Light Brown	Dark Brown	Brownish Black
	What is the natural color of your Hair?	Red or Light Blonde	Blonde	Dark Blonde or Light Brown	Dark Brown	Black
	What is the color of your skin? (*unexposed areas*)	Ivory White	Fair or Pale	Pale with Beige Tint	Olive or Light Brown	Dark Brown
	Do you have freckles on sun-exposed areas?	Many	Several	Few	Very Few	None
	How does your skin/face respond to sun exposure?	Always burns, blisters and peels	Often burns, blisters and peels	Burns, sometimes followed by peeling	Rarely Burns	Never had Burns
	Does your skin tan/turn brown?	Hardly or not at all	Light Color Tan	Reasonable Tan	Tan very easily	Turn Dark Brown Quickly
	Do you turn Brown several hours after sun exposure?	Never	Seldom	Sometimes	Often	Always
	How does your face respond to sun?	Very Sensitive	Sensitive	Normal	Very Resistant	Never had a problem
	When did you last expose yourself to the sun, tanning bed, or self-tanning creams?	More than 3 Months Ago	2-3 Months Ago	1-2 Months Ago	Less than 1-Month Ago	Less than 2 Weeks Ago
	Do you expose the area to be treated to the sun?	Never	Hardly Ever	Sometimes	Often	Always
Total:	**Score**	**Fitzpatrick Skin Type**				
	0 – 6 **7 – 12** **13 – 18** **19 – 24** **25 – 30** **31+**	**I** **II** **III** **IV** **V** **VI**				

COSMETIC PROCEDURE INFORMATION & POLICIES

Please read and *initial each paragraph* indicating that you understand the following regarding cosmetic treatments at Southwest Contemporary Women's Care, such as hair and vein reduction, laser skin treatments, chemical peels, microneedling, Plasma Pen® treatments, skin care, and injections of Botox® Cosmetic and the Juvéderm® family of products:

________ I understand that the procedure to be done is a cosmetic procedure. I understand that cosmetic procedures/services are "not medically necessary" and cannot be filed with any insurance company for payments or reimbursement. I agree to be personally and fully responsible for payment for the procedure.

________ I understand that cosmetic procedures are not an exact science. Although our staff strives for the best results with all treatments, the efficacy may vary among individuals. I may see excellent results, partial results, or no results. I will not expect or request refunds for cosmetic procedures.

________ I understand that children and guests are not permitted in the procedure room for any reason due to significant safety risks.

________ I understand that photographs may be taken before, during and after any procedure. This consent authorizes Southwest Contemporary Women's Care and its staff to use photographs taken of me for medical education of staff within the clinic and documentation of my medical record. I release and hold harmless the clinic, staff, and consultants from any liability in connection with such materials.

________ I understand that forty-eight (48) hours' notice is required for appointment cancellations and reschedules. Because unused appointments waste valuable time and prevent others from getting appointments, there is a $75 "no-show" fee for a late cancellation, reschedule or missed appointment. As a courtesy, we send a text reminder for appointments and you can confirm or cancel by responding to the text. You can also call or leave us a voice message at any time should you need to cancel or reschedule.

I have read and understand the above policies.

____________________	____________________	____________________	__________
Patient-Print Name	*Patient Signature*	*Witness Signature*	*Date*

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