Aesthetics
at SOUTHWEST CONTEMPORARY WOMEN'S CARE

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: _____

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: _____

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, Vivace® radiofrequency microneedling, 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 **at least 72 hours' notice** is required for appointment cancellations and reschedules. When you book your appointment, we reserve that time for you; it is no longer available to other patients. Out of respect for our staff and our other patients, there is a "late cancellation" fee for a late cancellation, late reschedule or missed appointment. Late cancellation fees are intended to cover some of the costs and expenses when your reserved spot is not filled. If you are more than 10 minutes late for your appointment, it is considered a missed appointment. Late cancellation fees are $250 for filler injection appointments and Vivace appointments, $100 for Botox injection appointments, and $75 for other aesthetics appointments. *As a courtesy, we send a text reminder for appointments and you can confirm or reschedule by replying to the text.* You can also call or leave us a voice message should you need to cancel or reschedule an appointment.

I have read and understand the above policies.

_____	_____	_____	_____
Patient-Print Name	*Patient Signature*	*Witness Signature*	*Date*

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**				