ESSENTIAL AESTHETICS PATIENT INTAKE FORM

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Board Certified Providers

We are pleased to welcome you to our practice. You can feel confident that our providers and staff are committed to meeting your specific needs. Please take a few moments to fill out this form as accurately as possible. All fields are mandatory. If you have any questions, we will be happy to help you.

Today's Date: _____ Male _____ Female _____

Name: _____
First Middle Last

Date of Birth: _____/_____/_____ Age: _____

Address: _____
Street Number/Name City State Zip Code

Home Phone: (_____) _____ Cell: (_____) _____ Work Phone: (_____) _____

Would you like to receive text reminders? Please circle one: Yes No

Employer: _____ Occupation: _____

Name of primary care physician: _____ Phone number: (_____) _____

Emergency Contact

Name: _____ Phone number: (_____) _____ Relationship: _____

How did you hear about us?

- ☐ Provider Referral – name: _____
- ☐ Friend/Relative – name: _____
- ☐ Google
- ☐ Yelp
- ☐ Other (please specify): _____

What would you like to discuss with our provider today?

- ☐ Botox/Dysport
- ☐ Dermal Fillers
- ☐ Coolsculpting
- ☐ Chemical Peels
- ☐ Laser Hair Removal
- ☐ Hair Loss
- ☐ Kybella
- ☐ Photofacial
- ☐ Fractional Resurfacing
- ☐ Liquid Face Lift/Skin Tightening
- ☐ Mole/Skin Tag Removal
- ☐ Sun Spots/Brown Spots/Rosacea
- ☐ Tattoo Removal
- ☐ Radiofrequency Microneedling
- ☐ Spider Vein Treatment
- ☐ Other: _____

Do you have any medical problems? Please list any past history of serious illness, current, or chronic conditions:

_____

_____

_____

Please list any previous surgeries, and their dates, including any cosmetic surgeries:

_____

_____

_____

Do you have any drug allergies/sensitivities? If so, please describe symptoms: _____

_____

_____

Are you allergic to latex, lidocaine, sulfa medications, hydroquinone, aloe, or bee stings? (Please circle)

Do you have any bleeding tendencies? _____

Do you smoke? _____ **Pack(s)/day?** _____ **Number of years?** _____

Do you drink alcohol? Yes No **How much?** _____

Please list all medications you are currently taking:

	Name	Dosage	Frequency
1.			
2.			
3.			

Are you or is it possible that you are pregnant? Yes No **Are you breastfeeding?** Yes No

Do you use sunscreen daily with SPF 30 or higher? Yes No

List your common physical/outdoor activities: _____

_____

Do you presently have or have you ever experienced any of the following? (please check all that apply):

- ☐ Accutane
- ☐ Active Skin Infection
- ☐ Asthma
- ☐ Cancer
- ☐ Cold Sores
- ☐ Decrese in Hair
- ☐ Diabetes
- ☐ Easy Bruising or Bleeding
- ☐ Eczema
- ☐ Epilepsy or Seizure History
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ Herpes (genital)
- ☐ High Blood Pressure
- ☐ Hyperpigmentation
- ☐ Hypopigmentation
- ☐ Increase in Hair
- ☐ Low Blood Pressure
- ☐ Lupus
- ☐ Migraine Headaches
- ☐ Moles
- ☐ Nerve or Muscle Disease(s)
- ☐ Permanent Makeup or Tattoos
- ☐ Seasonal Allergies/Allergic Rhinitis
- ☐ Shingles
- ☐ Skin Cancer
- ☐ Thyroid Imbalance

I certify that the information I have given is complete and accurate.

I understand that it is my responsibility to advise this office of any changes in the information provided above.

I understand that Essential Aesthetics has the right to refuse service to anyone for any reason (including medical)

_____ _____

Signature
Patient/Parent/Guardian

Print Name

I have thoroughly discussed the above information with the patient and responded to all questions, at which point the patient provided informed consent to undergo the procedure(s) discussed.

Reviewed by: _____ Date: _____/_____/_____
Elham Zarnegar, PA-C

Medical Director: _____ Date: _____/_____/_____
Abishai Rumano, MD
