Name _____

Address _____

City _____ State _____ Zip _____

Home Phone _____ Email _____

Cell Phone _____ Can we contact you by text message? _____

Today's Date _____ Date of Birth _____

Referred by _____

We're Social!
Follow @themedsparpsc on ; themedspa on ; themedsparpsc on

Let us follow you too: _____

Are you a patient at Raleigh Plastic Surgery Center? ☐ Yes ☐ No

If so, who is your physician? _____

1. Have you ever been diagnosed with any of the following skin disorders? *Check all that apply*

☐ Acne ☐ Seborrhea ☐ Psoriasis ☐ Skin Cancers ☐ Mycosis(fungal infection)

☐ Contact Dermatitis

Have you ever been diagnosed with any of the following? *Check all that apply*

☐ Anxiety ☐ Depression ☐ Cancer ☐ Hemophillia ☐ Diabetes ☐ Hepatitis ☐ Migraines

☐ Thyroid ☐ Herpes ☐ Asthma ☐ Epilipsy ☐ HIV ☐ Sinus Problems ☐ Heart Problems

☐ High or Low Blood Pressure ☐ Other: _____

2. Do you suffer from any allergies? **Important**

Cosmetic ingredients, food, iodine, sulfer, medications, hay fever, latex: ☐ Yes ☐ No

If yes, please specify _____

_____

3. Are you currently undergoing chemotherapy or radiation therapy?

☐ NO ☐ YES (please specify) _____

4. Are you currently taking any medications, herbs, vitamins?

Internal: _____

External: _____

5. Have you ever been prescribed Accutane®?

☐ NO ☐ YES If yes, last date used? _____

6. Do you have any body implants? ☐NO ☐YES If so, please specify _____

7. Do any of the following apply to you?

☐ Smoke ☐ Exercise ☐ Eat Spicy Foods ☐ Wear Contact Lenses

8. When exposed to the sun, do you?

☐ Burn Easily ☐ Tan Easily ☐ Burn Then Tan ☐ Fever Blisters

9. How often do you consume alcohol? ☐ Regularly ☐ Seldom ☐ Never

10. How many glasses of water do you consume daily? ☐1-2 ☐3-5 ☐6-8+

For Women Only ... *Check all that apply*

☐ Regular Menstruation ☐ Pregnant ☐ Hormonal Problems ☐ Menopause

☐ IUD (copper or plastic) ☐ Lactating ☐ Birth Control Pill ☐ Hemophilia ☐ Hepatitis ☐ Herpes

☐ HIV ☐ Other _____

**For an effective treatment, please be as accurate as possible

Skin Type

☐ Normal ☐ Dry ☐ Sensitive ☐ Combination ☐ Oily ☐ Sensitive/Breakout

☐ Very Sensitive/Rosacea ☐ Acne ☐ Mature

What are your present skincare concerns? *Check all that apply*

☐ Crows Feet/Wrinkles ☐ Puffiness ☐ Lack of Elasticity ☐ Dark Shadows

☐ Hyper pigmentation ☐ Whiteheads ☐ Ingrown Hairs ☐ Enlarged Pores

☐ Papules or Pustules (inflamed) ☐ Blackheads ☐ Severe Sun Damage

Have you ever received any of the following medical or surgical procedures?

☐ Rhytidectomy (Face lift) ☐ Rhinoplasty (Nose) ☐ Blepharoplasty (Eye lift)

☐ Laser Resurfacing ☐ Dermabrasion

☐ Medical Acid Peels ☐ Collagen Injections ☐ Restylane Injections ☐ Botox® Injections

☐ Other_____

What is your current skincare regimen?

☐ Cleanser ☐ Toner ☐ Moisturizer ☐ Exfoliator ☐ Mask ☐ Make-up ☐ Sunscreen

☐ Brand(s) _____

If you could improve one thing about your skin, what would it be?

_____

_____

Thank you for choosing The MedSpa at Raleigh Plastic Surgery Center as your skin care specialist. Your treatment options and consent will be discussed during your complimentary consultation and possible treatment(s) today.

Consent for Treatment

I hereby consent to and authorize The MedSpa to perform the following procedure(s): chemical peels, dermaplane, micro-needling, facials, waxing, make-up application, extractions, all aesthetic services, product recommendations, and any other procedures recommended.

The nature and the purpose of the treatment(s) have been explained to me, along with the risks and hazards involved by The MedSpa, and I have voluntarily elected to undergo the treatment/procedure(s).

I also recognize there are no guaranteed results and that individual results are dependent upon age, skin condition, and lifestyle. I am aware that there is the possibility I may require further treatments to the treated areas to obtain the expected results at an additional cost which have been explained to me.

I understand how important it is to follow all instructions given to me for post-treatment care. In the event that I may have additional questions or concerns regarding my treatment or suggested home product/post-treatment care, I will consult The MedSpa immediately. I have also, to the best of my knowledge, given an accurate account of my medical history, including all known allergies or prescription drugs or products I am currently ingesting or using topically.

I have read and fully understand this agreement and all information detailed above. I understand the procedure(s) and accept the risks. All of my questions have been answered to my satisfaction and I consent to the terms of this agreement. I do not hold the aesthetician or The MedSpa, whose signature appears below, responsible for any of my conditions that were present but not disclosed at the time of this skin care procedure which may be affected by the treatment performed today or any future treatments.

The MedSpa at Raleigh Plastic Surgery Center Policies

_____(please initial) A 24-hour cancellation notification is required to avoid a cancellation fee of $25. No refunds and/or exchanges on retail products

_____ (please initial) For safety reasons, children are not allowed in the treatment room or left unattended in The MedSpa at Raleigh Plastic Surgery Center.

Client Name(signature)_____ Date_____/_____/_____

The MedSpa (witness)_____ _____Date:____/_____/_____

Smoking Risk Consent

The MedSpa in conjunction with Raleigh Plastic Surgery Center stands by their commitment in providing information, products, and services to achieve the best possible cosmetic outcome.

The MedSpa recommends smokers abstain from nicotine or nicotine substitutes for a minimum of 6 weeks before and after in office procedures and treatments. Carcinogens from smoke and secondhand smoke may impact your treatment and desired end result.

There is greater risk in smokers for bad scarring, hemotoma formation, intraoperative bleeding, bleeding, poor or delayed healing, hair loss, sloughing of the skin (skin loss), infection, increased or prolonged bruising and hyperpigmentation.

I ACKNOWLEDGE THAT I HAVE READ AND FULLY UNDERSTAND THE ABOVE CONSENT TO HAVE PROCEDURES AND TREATMENTS PERFORMED. I UNDERSTAND THE POTENTIAL RISKS INVOLVED AND THE POSSIBLE IMPACT CONTINUED SMOKING HAS ON MY DESIRED COSMETIC RESULT AND WISH TO PROCEED WITH TREATMENT.

Patient Signature)_____ Date_____/_____/_____

Witness _____ Date:____/_____/_____

Medical Records Release

Date:_____

Patient Signature:

_____ _____

Print Patient Name:

_____

Date of Birth:

_____

** To protect your privacy in accordance with HIPAA standards, photo id must accompany your request for release of your medical records. If you are faxing this form to our office, please include a faxed copy of a photo id that also contains your signature (ie: driver's license). If you are presenting this form in person, please be prepared to present photo id which also contains your signature.**

By signing this document, you agree to the exchange of records between:

Raleigh Plastic Surgery Center & The MedSpa at Raleigh Plastic Surgery Center.