the MedSpa

Patient Information

Name _____ Today's Date_____

Address_____ City _____ State_____Zip _____

Home Phone _____Cell Phone_____Can we text you?Yes___No___

Date of Birth _____ Referred By_____

Are you a patient at Raleigh Plastic Surgery Center?Yes__No__ If so, which doctor?_____

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Let us follow you too:_____

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

2. What are your present skincare concerns? CrowsFeet/Wrinkles_____Puffiness____Englarged Pores_____

Lack of Elasticity_____Darkpigmentation_____Whiteheads_____IngrownHairs_____Blackheads_____

Papules or Pustules(inflamed)_____SevereSunDamage_____

3. SkinType: Normal____Dry____Sensitive____Combination____Oily____Acne____Mature_____Rosacea_____

4. When exposed to the sun,doyou? BurnEasily____TanEasily____Burn thenTan____FeverBlister_____

5. Have you ever been prescribed Accutane®? Yes____No____ Last date used_____

6. What is your current skincare regimen?

Cleanser_____Toner_____Moisturizer_____Exfoliator_____Mask_____Makeup_____Sunscreen_____

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

Rhytidectomy (facelift)_____Rhinoplasty(Nose)_____Blepharoplasty (Eye Lift)_____ Medical Acid Peels_____

Laser Resurfacing___Dermabrasion_____Collagen Injections____Restylane Injections___Botox___Other_____

8. For Women Only --- Regular Menstruation_____Pregnant_____IUD_____Lactating_____Hepatitis_____

Hormonal Problems____Menopause____Birth Control Pill____Other_____

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

Cosmetic ingredients__ food__ iodine__sulfer__medications__hay fever__latex__specify_____

10. Are you currently taking any medications, herb and/or vitamins? Yes____No____

Internal_____External_____

11. Are you currently undergoing chemotherapy or radiation therapy? Yes_____No_____

12. Have you ever been diagnosed with any of the following skin disorders? Acne___Psoriasis____

Seborrhea____Skin Cancers___ Mycosis(fungal infection)____Contact Dermatitis_____

13. Have you ever been diagnosed with any of the following? Heart Problems__Anxiety__Thryroid__

Depression___High or Low Blood Pressure____Diabetes____Hepatitis_____Migraines__Asthma___HIV___

Epilipsy_____Herpes_____Hemophillia____SinusProblems___ Other_____

Consent for Treatment

I hereby consent to and authorize The MedSpa@RPSC. 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@RPSC, and I have voluntarily elected to undergo the treatment/procedure(s).

I also recognize there are no guaranteed results and that independent results are dependent upon age, skin condition, and lifestyle and that there is the possibility I may require further treatments of the treated areas to obtain the expected results at an additional cost 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@RPSC 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@RPSC 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@RPSC 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.

Client Name(signature)_____ Date_____/_____/_____ The MedSpa@rpsc (signature) _____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@RPSC 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:____/_____/_____