

**PATIENT INFORMATION**

Last name:		First:	Middle:	Birth date: / /	
Street address / PO Box:			Social Security #		Home phone # ( )
City:		State:	ZIP Code:	Cell Phone # ( )	
Email:		Are you new to our Spa? If so, who referred you? (NAME)			Known Drug Allergies:

Have you ever experienced a reaction to products? Please explain: \_\_\_\_\_

Current Medications: \_\_\_\_\_

 If you are female, are you pregnant or trying to conceive?  Yes  No

Are you currently using a skin care regimen? If so, which one? \_\_\_\_\_

Do you have any problems with your skin? \_\_\_\_\_

 Have you ever had an adverse reaction to a cosmetic procedure?  Yes  No

How did you hear about us?

- |                                   |                                    |   |   |   |
|-----------------------------------|------------------------------------|---|---|---|
| <input type="checkbox"/> Family   | <input type="checkbox"/> Friend    | <input type="checkbox"/> Close to home/work | <input type="checkbox"/> Prestige Website | <input type="checkbox"/> MedSpa Website |
| <input type="checkbox"/> Facebook | <input type="checkbox"/> Instagram | <input type="checkbox"/> Other _____        |   |   |

Other family members seen here:

I release Prestige Medspa, Medical Staff, and specific technicians from liability associated with \_\_\_\_\_ procedure. I certify that I am a competent adult of at least 18 years of age. This consent form is freely and voluntarily executed and shall be binding upon my spouse, relatives, legal representatives, heirs, administrators, successors and assigns.

**PRESTIGE MEDSPA POLICIES:**

- |   |  |
|---|--|
| 1 | The Prestige MedSpa reserves the right to not treat any patient with questionable medical conditions such as open sores or wounds, infectious diseases, etc.   |
| 2 | Our office has a 24-hour cancellation policy. Kindly inform the office within 24 hours if you cannot keep your appointment. There will be a \$25 cancellation fee for no show appointments or same day cancellations |
| 3 | Results vary from client to client. There are no guarantees on any services and no refunds.  |
| 4 | We do not accept checks. We do accept every other type of payment.   |
| 5 | We will always maintain the highest level of client confidentiality.   |

 \_\_\_\_\_  
*Patient signature*

 \_\_\_\_\_  
*Date*