medical spa
beauty · science · spirit

Patient Information

Date __ / __ / ____

Name (First) _____ (Last) _____ (MI) ____

Address _____

City _____ State _____ Zip _____

Preferred Phone Number _____ Cell / Home May we leave a message? YES NO

Preferred method of communication from our office? (please circle all that apply) TEXT CALL EMAIL

Date of Birth __ / __ / ____ Age __ Sex M / F Marital Status _____

Emergency Contact Name _____

Relationship _____ Phone Number _____

How did you hear about us? _____

Reason for consultation today _____

Please describe your skin and skin concerns by checking all that apply:

__ Thick	__ Dry	__ Active Acne	__ Sallow
__ Thin	__ Normal	__ Acne Scars/Scars	__ Puffiness
__ Saggy	__ Oily	__ Blackheads/Whiteheads	__ Rosacea
__ Firm	__ Combination	__ Cysts	__ Dehydrated
__ Fine lines	__ Large pores	__ Dark spots/patches	__ Eczema or Psoriasis
__ Wrinkled	__ Sun freckles	__ Scaling/flaking	__ Dark circles/eyes
__ Aging	__ Uneven/blotchy	__ Broken capillaries	__ Other_____

Signature _____ Date: __ / __ / _____