New Patient Intake Form

Patient Name:____ Date:______________________

Street Address: ____

City:___________________________ State:_________ Zip Code:__________ Date of Birth:______________

Home #:______________________ Work#____________________ Cell#____________________________

Best number to confirm appointments: Home, Work or Cell. Email:____________________________________

How did you hear about us (please circle): AZ Health & Living North Valley Magazine Internet Website Facebook Instagram Phoenix Top Doc Magazine Face USA Drove By Client Referral (Please specify name, so they can get a referral bonus) Name:________________________________ Other:____________________

Patient Concerns

Lines/Wrinkles	☐ Yes	☐ No	Redness/Rosacea	☐ Yes	☐ No
Skin Laxity	☐ Yes	☐ No	Veins	☐ Yes	☐ No
Skin Texture/Scarring	☐ Yes	☐ No	Acne	☐ Yes	☐ No
Brown Spots/Hyperpigmentation	☐ Yes	☐ No	Dermatitis	☐ Yes	☐ No
Skin Growths	☐ Yes	☐ No	Other:________________________	☐ Yes	☐ No

Are you interested in a specific procedure or service? ☐ No ☐ Yes:______________________________________

Cosmetic Procedure History

Please indicate which treatments you have had:

Neurtotoxis: Botox/Dysport	☐ Yes	☐ No	Laser Hair Removal	☐ Yes	☐ No
Dermal HA Fillers: e.g Juvederm	☐ Yes	☐ No	PhotoFacial/IPL	☐ Yes	☐ No
Fillers: Sculptra, Artefill, Collagen	☐ Yes	☐ No	Laser Vein	☐ Yes	☐ No
Laser Skin Resurfacing	☐ Yes	☐ No	Cellulite/Fat Loss	☐ Yes	☐ No
Laser Skin Tightening	☐ Yes	☐ No	Peels/Microderms/Facials	☐ Yes	☐ No

☐ Cosmetic Surgery ____ Year_______________

____ Year _______________

____ Year_______________

1) Adverse reactions to any of the above? ☐ Yes ☐ No ______________________________________

2) Were you pleased with results? Yes ☐ No ☐ ______________________________________

New Patient Intake Form

PHYSICIAN SKIN SOLUTIONS at Arrowhead

Patient Medical History

Condition	Yes	No	Condition	Yes	No
Diabetes	☐ Yes	☐ No	Neuromuscular Disorder/Bell's Palsy	☐ Yes	☐ No
Herpes or Cold Sores	☐ Yes	☐ No	Hernia:_______________________	☐ Yes	☐ No
Active Implants: Pacemaker/Defibulator	☐ Yes	☐ No	Epilepsy/Seizures	☐ Yes	☐ No
Metallic Implants	☐ Yes	☐ No	Autoimmune Disease	☐ Yes	☐ No
Hemorrhagic or bleeding disorders	☐ Yes	☐ No	High Blood Pressure	☐ Yes	☐ No
Pregnant or Lactating	☐ Yes	☐ No	Heart Disease	☐ Yes	☐ No
Migraines	☐ Yes	☐ No	Liver Disease	☐ Yes	☐ No
Anxiety/Depression	☐ Yes	☐ No	Immune Compromised/HIV	☐ Yes	☐ No
Neuropathy	☐ Yes	☐ No	IUD/Mesh Implants	☐ Yes	☐ No
Recent Dental Work	☐ Yes	☐ No	Iodine/Latex Allergy _______________	☐ Yes	☐ No

List any chronic Illnesses: ____

List any Drug Allergies:____

Other Allergies we should be aware of:____

Current Topical Creams/Ointments/Solutions:____

List all **medications and/or supplements** below. Be sure to include all prescription and non-prescription medications. If you are not taking any medications or supplements. Please Initial here:___________

Medication	Disease/Reason	Dose	Frequency	Date Started	Date last Taken

Are you currently taking any of the following:

	Yes	No		Yes	No
Anticoagulants or antiplatelet drugs	☐ Yes	☐ No	Accutane within the last 12 months	☐ Yes	☐ No
Immunosuppressant	☐ Yes	☐ No	Anti-Inflammatories/NSAIDS	☐ Yes	☐ No

Ethnicity/Ethnic Background: ____(Important for Laser Treatments)

Please Circle the one that applies the most:

Smoking History	Never Smoked	Ex-Smoker	Light Smoker	Heavy Smoker #Years ____________
Health	No Health Issues	Minor Health Issues	Moderate Health Issue	Chronic Health Issues
Sun Exposure	Rarely in Sun	Occasionally in Sun	Frequently in Sun	In Sun Daily
Sunscreen	Never Use	Occasionally Use	Always Use	
Alcohol Intake	Never	Daily	Weekly	Occasionally/Social
Weight	Rarely Fluctuates	Fluctuates Often	Plan on Losing Weight	Currently Losing

New Patient Intake Form

Patient Expectations

Patient understands that cosmetic/aesthetic procedures are elective and are not meant to replace or substitute for surgical results. _______________Pt Initials

Patient understands that we recommend a consultation so we can provide a comprehensive plan to meet your goals.____________Pt Initials

Patient understands we provide a multi-phase plan to meet your goals, but no guarantees or promises can be made for results*. ____________Pt Initials

Patient understands that if the entire recommended plan is not completed, then expectations should be re-evaluated. * _______________Pt Initials

Patient understands that if the entire recommended plan is not completed, and they are dissatisfied with the results of the portion of the plan they chose to proceed with, any follow ups to address expectations not met will be at charge of $100.00.* _______________Pt Initials

Patient understands that they must wait a week after Botox or Filler injections to schedule touch ups. This allows time for the products to work and for swelling to go down. ______ Pt Initials

Botox Touch ups are at no charge for new patients within the first two weeks; provided they purchased the recommended units made by the injector. _______Pt Initials

Filler touch ups are at no charge for two weeks after the initial injection, provided they have some product left in their syringe. After two weeks, touch ups are $25 with the RNs and $50 for the doctor. _______Pt Initials

Rewards Programs

Are you enrolled or do you wish to be enrolled in **Brilliant Distinctions** the loyalty rewards program from Allergan? Allergan is the maker of Botox, Juvederm, Voluma, Latisse and Skin Medica . With Brilliant Distinctions you earn points for purchasing any of their products, and the points earn you coupons that can be applied to future treatments or purchases of Allergan products. You must have an e-mail address to enroll.

☐ I am enrolled ☐ Yes, Please enroll me ☐ No, I do not wish to be enrolled at this time.

Member Id #_________________________________

Are you enrolled or do you wish to be enrolled in Galderma's loyalty **Aspire Program?** Galderma is the maker of Dysport, Restylane and Sculptra products. With Aspire you earn points for joining and for purchasing their products, and the points you earn you coupons that can be applied to future treatments or purchases of Galderma products.

☐ I am enrolled ☐ Yes, Please enroll me ☐ No, I do not wish to be enrolled at this time.

New Patient Intake Form

Patient Signature:____Date:____________________

* Applicable for patients having consultations where a phased plan is developed to meet concerns