Esteem
Medical Spa & Salon

Client Information

Date: _____

Last Name: _____ First Name: _____

DOB: _____

Address: _____

City: _____ State: _____ Zip_____

Home Phone: _____Cell Phone: _____

Email_____

Preferred method of contact: Home / Cell / Text / Email

Emergency Contact Name: _____ Phone: _____

Would you like to receive our email newsletter with special offers and new products? Yes / No

Employer: _____ Employer Phone: _____

Primary Physician: _____Dermatologist: _____

Are you currently under the care of another skincare professional?: _____

Do you use sunscreen regularly? Yes / No Brand: _____ SPF: _____

How did you hear about us? (Please circle below)

Newspaper / TV / Radio / Internet / Website / Google / Facebook / Yelp / Friend / Family Member

Referred by: _____ Other: _____

Reason for your visit today? _____

Have you researched procedures related to your visit today? (circle) YES NO

How long ago did your research begin? (circle)

1–3 weeks 1 month 2-3 months 3-6 months 6 months +

How much improvement are you expecting? (Please circle one)

100% 80-90% 60-70% 40-50% 20-30%

When you look in the mirror, what 3 things would you change?

1._____

2._____

3. _____

Payment Type: We accept cash, credit and debit cards for payment of services. A 5% charge will be subtracted for all credit card refunds. We do not accept CareCredit, insurance or checks.

It's About TIme
Esteem
Medical Spa
Dr. Michael J. Glass

Cosmetic History

Client Name _____ Date _____

Do you have any allergies? Yes / No If yes, to what? _____

What was your reaction? _____

Are you allergic to latex? Yes / No

What medications do you take? _____

Are you allergic to any of the following? Milk, Apples, Citrus, Grapes, Aloe Vera, Perfumes, Hydroquinone, Mushrooms, Aspirin, Alcohol Based Products. (Please circle)

Do you take tetracycline, doxycycline, minocycline, cipro? (Please circle)

Do you use birth control pills? Yes / No

Do you use glycolic, lactic, or salicylic acid washes or home peels? Yes / No

Have you ever used any other cosmetic products that caused an undesirable reaction? Yes / No

If yes, what was the product/s, what was the reaction/s?

_____

Do you have sensitive skin? Yes / No Do you get rashes or breakouts easily? Yes / No

What causes you to breakout or get rashes? _____

Do you have oily skin? Yes / No

Do you have acne breakouts? Yes / No If yes, are they continuous or occasional? (Please circle)

Do you have menstrual related acne breakouts? Yes / No

Do you have acne in places other than the face? Yes / No

Do you have, or have you been told you have:

- Melasma
- Rosacea
- Skin Cancer
- Melanoma

Have you had Botox? Yes / No Have you had dermal fillers? Yes / No

Have you ever had any allergic reactions to waxing or depilatory procedures? Yes / No

If yes, what was the reaction? _____

MEDICAL HISTORY

Patient Name: _____

1. Do you have, or have you been treated for, any of the following conditions: (Circle) Heart disease, angina, heart attack, heart valve *problems, pacemaker, implanted defibrillator, high blood pressure,* diabetes mellitus, liver disease, hepatitis B or C, HIV, lupus, or a bleeding disorder?
2. Please list all surgeries you have undergone:

   _____

   _____

3. Are you pregnant or breast feeding? **Yes**☐ **No**☐
4. Are you on anticoagulation therapy, such a Coumadin, Plavix, or Aspirin? **Yes**☐ **No**☐
5. Do you smoke? How much? _____ **Yes**☐ **No**☐
6. Do you drink alcohol? Drinks per week? _____ **Yes**☐ **No**☐
7. Do you have, or have you had, problems with wound healing? **Yes**☐ **No**☐
8. Do you have a history of keloid formation, or hypertrophic scarring? **Yes**☐ **No**☐
9. Do you have a history of hyperpigmentation following a sun burn or cosmetic treatments? **Yes**☐ **No**☐
10. Have you had, or suffered from, cold sores, or have a history of herpes simplex virus? **Yes**☐ **No**☐
11. Are you being treated with, or ever had, gold therapy? **Yes**☐ **No**☐
12. Have you taken Accutane within the last year? **Yes**☐ **No**☐
13. Do you use RetinA or Retinols? **Yes**☐ **No**☐
14. Have you used a tanning bed in the last 60 days? **Yes**☐ **No**☐
15. Are you required to take antibiotics prior to dental procedures? **Yes**☐ **No**☐
16. Do you use steroids, or immunosuppressants, such as; Prednisone, Immuran, methotrexate, Embrel, or Remicade? (Circle)
17. Are you allergic to any local anesthetics, such as; benzocaine, lidocaine, tetracaine, novacaine or Marcaine? (Circle)
18. Are you allergic to any antibiotics, or pain medications, such as; Pencillin, Amoxicillin, Doxycycline, Demerol, Vicoden (hydrocodone), or Percocet (oxycodone)? (Circle)
19. What prescription medications do you take on a regular basis? (List all)

    _____

    _____

20. Do you take aspirin, ibuprofen, NSAIDS, Vitamin E, St. John's Wart, ginkgo, or garlic supplements? If yes, please circle which substance(s) and date last taken _____
21. Do you have permanent make-up; eyebrows, eyelids, lips, other? (List all)_____
22. Do you have myasthenia gravis, or Eaton-Lambert syndrome? (Circle)
23. What is your ethnic background? _____

By signing this document, I acknowledge that I have provided accurate information pertaining to my medical history, and I understand that it is my responsibility to alert the staff of Esteem Medical Spa and Salon to any changes in my health, including, but not limited to, pregnancy, medical or surgical treatments not listed, or changes in medications.

_____ _____

Signature Date

_____ _____

Consultant Signature Date

Payment Policy

Charges and fees for services to be rendered will be discussed with you prior to treatment. Services will require payment prior to your treatment. Services offered at Esteem Medical Spa are considered elective cosmetic procedures and are not eligible for insurance reimbursement. There are no refunds for any procedures. **Procedures initiated but not completed as a result of patient choice will not be refunded.** A $30.00 fee will be added to returned checks.

Elective Procedures: All procedures performed by the staff of Esteem Medical Spa are elective, cosmetic procedures. The clinician performing your treatment will use every means possible to make you comfortable during your procedure; however, you may experience some level of discomfort during your procedure. While the staff will undertake to perform all procedures to the best of their abilities, there is no guarantee, offered or implied, that a particular result will be achieved.
Once a treatment is in progress there will be no refunds for the treatment. Should you request termination of a treatment in progress, for any reason, the treatment will be considered complete.

Series: Procedures which require multiple treatments may be offered as a Series. Discounts may be available for treatments purchased as a series. The discount will only be available if all treatments in the series are paid for in full, prior to the scheduling of the initial treatment. Any part of a series which is not used by the patient, at the patient's request, will remain as a credit in the patient's account. This credit can be applied toward other services the patient may wish to obtain. No refunds for prepaid series will be given. Account credit given as a result of an incomplete Series is not transferable.

Fillers: Fillers are sold by the syringe. Unused, partial syringes of filler will be disposed of. Clients using a partial syringe will be responsible for payment for the entire syringe. The doctor will discuss the possibility of partial syringe usage during the appointment and request your approval prior to opening a full syringe for partial usage. Payment is due in full at the time of service.

Test Spot Policy: Test spots are $100.00.
It may be necessary to perform a test spot in the area of a proposed laser/IPL treatment to determine safe energy levels for your skin. If results of the test spot so indicate the proposed treatment(s) are safe to begin, one half the cost of the test spot will be applied to the cost of the first treatment, or to the prepayment of a Series.

Cancellation Policy: We value your time; therefore, your appointment time is set aside especially for you. We, in turn, require 24 hours' notice for cancellation or to reschedule of an appointment of 30 minutes or more. A $100 charge may be assessed for cancellation or no show of an appointment greater than 30 minutes without proper notice. This fee will be assessed against credit on account or will be required to be paid prior to rescheduling of the appointment. **Patients that are 15 minutes or more late for a scheduled procedure will be rescheduled at the discretion of the clinician.** Please understand that this policy is enforced to ensure timely service to each of our patients.

Payment Type: **We accept cash, and credit or debit cards for payment of services**. A 5% charge will be subtracted for all credit card refunds.

Appointment Schedules: The clinician/doctor will tell you when your next appointment should be scheduled. It is very important that you return for follow up appointments in the intervals recommended.

I have read, understand, and accept the terms of the policies outlined herein.

Print Name	Signature	Date