beverly hills plastic surgery®

CLIENT REGISTRATION

Patient

Name: ______________________ Date: __________

Address: ______________________ City: ________ State: ______ Zip: ________

Home Phone: (____)__________ Cell Phone: (____)____________ Other Phone: (____)______________

Email: ______________________ Restrictions for contacting you? _____ yes _____ no

Contact Restrictions : (Specify) ______________________

Age: ______ Birth Date: ___________ Height: _________ Weight: __________ Gender: M / F

Marital Status: _____ Single _____ Married _____ Other Spouse/Partner's Name:______________________

Patient's Employer/School: ______________________ Occupation: ______________________ Full/Part Time

Work Phone: (____)______________ Ext. ______ Is it okay to call you at work? _____ yes _____ no

Work Address: ______________________ City: ___________ State: _____ Zip: _______

How did you hear about us? ______________________

Emergency Contact

Name: ______________________ Relationship to patient: ______________________

Emergency Contact Address: ______________________

Home Phone: (____)__________ Cell Phone: (____)______________ Other Phone: (____)____________

Health Information

1. Are you pregnant? ❒ Yes ❒ No
2. Are you nursing? ❒ Yes ❒ No
3. Do you smoke? ❒ Yes ❒ No
4. Do you have any metal implants? ❒ Yes ❒ No
5. Do you smoke regularly? ❒ Yes ❒ No
5. Do you participate in vigorous aerobic activity/sports? ❒ Yes ❒ No How often? _________ times per week
6. Do you wear contact lenses? ❒ Yes ❒ No
7. Do you wear sunscreen on a regular basis? ❒ Yes ❒ No
8. Have you visited a tanning booth within the last 3 weeks? ❒ Yes ❒ No **If so, your service may be rescheduled.*
9. Are you currently taking any antibiotics? ❒ Yes ❒ No
10. Do you have HIV? ❒ Yes ❒ No
11. Have you ever had:

Cold sores?	❒ Yes	❒ No	If so, how often ___________	Last Breakout & Area ______________
Herpes?	❒ Yes	❒ No	If so, how often ___________	Last Breakout & Area ______________
Hives?	❒ Yes	❒ No	If so, how often ___________	Last Breakout & Area ______________
Keloids?	❒ Yes	❒ No	If so, how often ___________	Last Breakout & Area ______________

12. Please list all medications that you take regularly, including hormones, vitamins and the like: ___________________________

____

13. Do you have any allergies? Are you allergic to any medications? Skin care products? If yes, please list allergies: __________

____

Skin Care Related

1. Are you currently using products containing:
   Glycolic Acid: ❒ Yes ❒ No
   AHA ❒ Yes ❒ No
   How long have you been using the product and how has your skin been reacting to it? ______________________________

   ____

2. Are you currently using Accutane or any other acne medication? ❒ Yes ❒ No How long ago? ___________________

3. Do you Retin-A, Renova or other topical vitamin A, or Hydroquinone (skin lightener)? ❒ Yes ❒ No

   How long ago? ____

4. Do you currently use wax, electrolysis or depilatories on your face? ❒ Yes ❒ No

   If so, when was your last treatment? ____

5. Are you using exfoliating acids? ❒ Yes ❒ No If so, which ones? ______________________________________

6. Have you had any of the following:
   Microdermabrasion? ❒ Yes ❒ No If so, when? ____

   Chemical Peel? ❒ Yes ❒ No If so, when? ____

   Laser Resurfacing? ❒ Yes ❒ No If so, when? ____

   Collagen or Botox? ❒ Yes ❒ No If so, when? ____

   Facial Surgery? ❒ Yes ❒ No If so, when? ____

7. Do you have permanent make up? ❒ Yes ❒ No If so, where? ____

8. To help us determine a facial regimen suitable for you, describe your skin type: (check only those that apply)

   ❒ thick ❒ thin ❒ saggy ❒ firm ❒ sensitive ❒ freckled/sun damaged
   ❒ normal ❒ dry ❒ rosacea ❒ acne scarred ❒ small pores ❒ mature/wrinkled
   ❒ unevenness ❒ melasma ❒ psoriasis ❒ resilient ❒ hypo/hyper-pigmentation
   ❒ T-zone/combination ❒ broken capillaries ❒ prone to breakouts

9. Skin tone:

   ❒ pale/white ❒ light ❒ medium ❒ reddish ❒ freckled ❒ olive
   ❒ light brown ❒ md brown ❒ dk brown ❒ black

10. Eye color:

    ❒ blue ❒ green ❒ hazel ❒ gray ❒ lt brown ❒ md brown
    ❒ dk brown

11. Hair color:

❒ blonde ❒ red ❒ lt brown ❒ md brown ❒ dk brown ❒black
❒ gray/silver ❒ white

12. What improvements would you like to see in your skin? ______________________________

____

13. What products do you currently use on your skin? ______________________________

____

14. What type of facial treatments did you last have? ______________________________

____

15. What did you enjoy most and least about the treatment? ______________________________

____

16. Have you been seen by a dermatologist before? ❒ Yes ❒ No If so, for what reason? ______________

17. Have you had a reaction from a skin care treatment? ❒ Yes ❒ No If so, please explain: ______________

____

18. Do you experience tightness or flakiness of your skin? ❒ Yes ❒ No

Esthetician's Comments: ____

____

Consent Agreement

Please take a moment to carefully review the information you have provided. If you have a specific medical condition or specific symptoms, certain esthetic treatments may be contraindicated and a referral from your primary care physician will be required prior to services being rendered. I, the undersigned, understand that the services I am receiving are provided for the basic purpose of relaxation. If I experience any discomfort during the session, I will immediately inform the esthetician. Because some procedures relating to skincare such as peels, diamond dermabrasion, body treatments and wraps should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions and answered all the questions honestly. I agree to keep the esthetician updated as to any changes in my medical profile and understand that there shall be no liability on the esthetician's part should I fail to do so. I am authorizing The SPA @ BHPS, Inc and the esthetician to perform facial services. I relieve The SPA @ BHPS, Inc from any liability resulting from an adverse reaction to any of the services provided.

Client Printed Name ______________________________ Date ______________

Client Signature ______________________________ Date ______________

Esthetician Signature ______________________________ Date ______________

Consent to Treatment of Minor

By my signature below, I hereby authorize a Licensed and Certified Aesthetician at Beverly Hills Plastic Surgery, Inc to administer facial treatment techniques to my child or depend as he/she deems necessary.

Signature ______________________________ Date ______________

Facial Appointments Cancellation Policy

Each client is provided with customized service and treatment at Beverly Hills Plastic Surgery, Inc. As such, we reserve 60-90 minutes per client appointment to ensure adequate treatment time and a personalized consultation. Please note that we require at least a 24-hour advanced notification for any changes or cancellations to your appointment. Without such advanced notice, your credit card will be charged with $50 which is applicable towards product purchases.

Beverly Hills Plastic Surgery, Inc. appreciates your patronage, and thanks you in advance for your understanding.

______________________________________ ______________

Client Name and Signature Date