Facial Enhancement | Skin Rejuvenation
Body Contouring | Hair Reduction | Anti-aging

CLIENT INFORMATION:

Name ______________________ Date of Birth ______________

Home Phone ______________________ Work Phone ______________________

Mobile Phone ______________________ E-mail Address ______________________

Mailing Address ____

City ______________________ State ______________ ZIP Code ________

May we contact you? ❑ Yes ❑ No

If yes, preferred contact methods?

❑ Home Phone ❑ Work Phone ❑ Mobile Phone ❑ E-mail ❑ Mail

In case of emergency, please contact:

Name ______________________ Phone Number ______________________

Relationship ______________________ Alternate Phone Number ______________________

How did you hear about us?

- ❑ Internet:
  - ❑ American Health & Beauty™
  - ❑ GETPROLO.com
- ❑ Another Client:
  - ❑ Whom may we thank? ______________________________________
- ❑ Albuquerque the Magazine
- ❑ Dex™ Official Directory
- ❑ Drove-by/Walked-in
- ❑ Another Physican:
  - ❑ Whom may we thank? ______________________________________
- ❑ Other ____

Have you visited our website?

❑ Yes ❑ No

To better suit your needs, when is the best day and time for an appointment?

❑ Monday ❑ Tuesday ❑ Wednesday ❑ Thursday ❑ Friday ❑ Saturday

❑ 9 am - 10 am ❑ 10 am - 12 noon ❑ 12 noon - 2 pm ❑ 2 pm - 4 pm ❑ 4 pm - 5 pm ❑ 5 pm - 6 pm

HEALTH HISTORY:

Are you currently under the care of a physician?

❑ Yes ❑ No

If yes, for what conditions are you being treated? ______________________________

____

____

Do you currently have any significant illnesses or have you had any significant illnesses in the past?

❑ Yes ❑ No

If yes, please list: ______________________________

____

____

Have you ever had surgery?

❑ Yes ❑ No

If yes, please list: ______________________________

____

____

Have you ever had any cosmetic procedures?

❑ Yes ❑ No

If yes, please list: ______________________________

____

____

Do you take any medications regularly?

❑ Yes ❑ No

If yes, please list (Please also list over-the-counter medications): ______________________________

____

____

Do you have any allergies or do you react to any medications?

❑ Yes ❑ No

If yes, please list: ______________________________

____

____

Do you currently have, or have you had in the past, illnesses of:

❑ Skin ❑ Brain or Nervous System ❑ Bladder or Kidneys

❑ Heart or Lungs ❑ Digestive System ❑ Muscles, Bones or Joints

❑ Eyes, Ears, Nose or Throat ❑ Liver ❑ Thyroid or Diabetes

PHOTOGRAPHY RELEASE:

I authorize Bair Medical Spa to take photographs of me and use them as an aid in my treatment. I understand that these photographs will help document the progress of my treatment. I hereby authorize and consent to the above-described photography.

Client’s Signature ______________________________ Date ______________________________

These photographs will be completely confidential unless signed below.
I hereby authorize and consent to the above-described photography being used by Bair Medical Spa for study reporting or promotional purposes and that any photographs taken will remain the property of Bair Medical Spa. If used for any of these purposes, I understand that my identity will be kept strictly confidential– no names will be released.

Client’s Signature ______________________________ Date ______________________________