PATIENT PROFILE

Name: ______________________________________ DOB: ____________ Age: ______
Address: ________________________________ E-Mail Address:___________________
City: ___________________ State: ___________ Zip: _____________
Contact Phone #: ________________________ Alternate Phone #: __________________

Are you pregnant? Yes _______ No _______ (If so, may need to decline treatment)
Do you wear contact lenses? Yes ______ No _______ (remove if eyes are sensitive)
Are you currently using accutane? Yes ______ No ______ How long? ______________
Are you currently using Retin-A or Renova? Yes _____ No _____ How long?________
Are you currently taking an antibiotic? Yes _____ No _____ If so, how long?________
Have you recently had facial waxing, laser hair removal, or use depilatories?
Yes _____ No _____ If so, when was last treatment or use? _______________________
How long since your last exposure to the sun or tanning booth? ____________________
Do you smoke? Yes _______ No _______ If so, for how long? ____________________
How much water do you consume daily (estimated)? ______________________________
Are you allergic to ? (Check all that apply): milk ______ citrus acids or fruits _________
Apples _____ aspirin ______ pumpkin ______ nuts _______ hydroquinone ________
Any other allergies? Yes ____ No _____ If so, to what? _________________________
Are you currently taking any medications (topical or oral) Yes _____ No ______
Have you ever had any adverse reaction or sensitivity to any type of facial treatment before? Yes _____ No _____ If so, please describe _____________________________

Please briefly describe your skin: ____

Describe your daily home care regimen: ____

Have you ever used any products that caused a bad reaction? Yes _____ No ______If so, what product and what type of reaction? ____

Please list any other information, questions, or concerns that you might feel would be of importance to you or the technician before beginning this treatment. If none, leave blank.

____

What are your three biggest skin concerns and improvements you'd like to see?
1-) ____

2-) ____

3-) ____

Patient/Client Signature: __________________________________ Date: ______________

If you are 15 minutes or more late to an appointment, you will need to reschedule for another time, this is to ensure all of our clients can be seen in a timely manner. All clients should call 24 hours before their appointment if they need to cancel. If you are unable or forget to call 24 hours in advance you will forfeit one treatment of your package, your booking fee or part of your gift certificate. Thank you for your awareness of our policy. We appreciate your visit and hope you enjoy your time at our Day Spa.

I, ________________________________ (please print) have read and agree to the above policy.

_________________________________ ___________________

Signature Date

PRIVACY PRACTICES ACKNOWLEDGEMENT

Cosmetic Plastic Surgery Institute and Day Spa

498 E 800 N – Stratford Park – Orem, Utah 84097

ACKNOWLEDGEMENT FORM

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Name ____ Birthdate ________________

Signature ____________________________________ Date ____________________

I wish Dr. Berg or his staff to share information with: _________________________.
Relationship:______________________________________.

I give my permission to confirm appointments by:

Message on answering machine YES NO

Message with family member YES NO

Message with anyone answering YES NO

Name of Patient (Print) ________________________ DOB _____________________

Signature of Patient ____________________________ Date _____________________

01/13/04 kj