MEDICAL SPA
AT PRO MEDICAL

NEW PATIENT INFORMATION

Date: _____ PRO Club Member: Yes No

PERSONAL HISTORY

Name: _____ Prefix: Mr. Mrs. Miss. Ms.

Preferred/nickname: _____

Address: _____ Exclude from mailings

City: _____ State:_____Zip Code: _____

Date of birth:_____ Marital Status: Single Married

Gender: Male Female Occupation: _____

Home Phone: _____ confirmation call do not use

Work Phone: _____ confirmation call do not use

Mobile Phone: _____ confirmation text confirmation call do not use

E-mail Address (we recommend using a personal email address to ensure delivery to your inbox):_____

May we contact you via e-mail for: specials/events contact to schedule routine appt. appt. confirmation reminder do not use exclude from mailings

Referring Physician: _____

How did you hear about us? PRO Club Member Magazine Radio TV Website _____

Other _____

EMERGENCY CONTACT:

Name_____ Relationship _____

Phone number _____

PRIMARY INSURANCE

Insurance Company: _____ Employer of insured: _____

Subscriber Name: _____ DOB: _____ Relationship: _____

Insurance ID #: _____ Group #: _____

INSURANCE:

Please read carefully and initial:

A: I (or my dependent) have insurance coverage and assign directly to PRO Club all insurance benefits, if any, otherwise payable to me for services rendered. I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the PRO Club practitioner to release all information necessary to secure the payment of benefits and authorize my signature below on all insurance submissions. (Initials: _____)

B: .I understand that co-payments are due at the time of service. (Initials: _____)

CANCELLATION POLICY:

PRO Club has a 24-hour cancellation policy, failure to provide proper notice will result in a $75 cancellation fee. Arriving late to a scheduled appointment time may result in a shortened or rescheduled appointment. (Initials: _____)

SIGNATURE

I certify that the information provided on this form is true and correct to the best of my knowledge. I give my permission for the practitioner to administer and perform such procedures as may be deemed necessary for treatment. By my initials above and signature below, I understand and agree to the above terms and conditions.

_____

AREAS OF INTEREST

Acne treatments
Botox/ Dysport
Cellulite reduction
Chemical peels
Dermal fillers
Laser hair removal
Laser tattoo removal
Photorejuvenation/ IPL
Skin care
Skin tightening
Skin resurfacing
Spider veins
SmartLipo MPX (body contouring)
Sweat Reduction

SKIN TYPE

Which of the following best describes your skin type?
(Check one skin type number)

Type I: very white or freckled - always burns, never tans
Type II: white - always burns, sometimes tans
Type III: white to olive - sometimes burns, always tans
Type IV: brown - rarely burns, always tans
Type V: dark brown
Type VI: black

MEDICAL HISTORY

Patient Signature – Age 18 or older Date

_____

Parent/Guardian- If patient is under age 18

MEDICAL HISTORY

Are you currently under the care of a physician? Yes No

If yes, who is your physician? _____

Are you currently under the care of a dermatologist? Yes No

If yes, who is your dermatologist? _____

What is your preferred pharmacy? _____

Do you have allergies to medications, food or to any of the following:

Latex Cosmetics Metal Iodine Aspirin Other: _____

History of non-melanoma skin cancer (basal cell or squamous cell carcinoma)

History of melanoma skin cancer

Sun induced precancerous skin lesions (actinic keratoses)

Arthritis

Cancer or family history of cancer

Eczema/atopic dermatitis

History of precancerous/atypical moles

Psoriasis

Polycystic Ovarian Syndrome

Skin disease

Varicose veins

Angina/history of MI

Keloid scarring

Heart arrhythmia

Thyroid imbalance

Herpes

Fainting with needles

Hepatitis

Bleeding or blood clotting disorders

HIV/Aids

High blood pressure

Poor wound healing

Seizures/epilepsy/convulsions

Diabetes

Depression/ psychiatric

Migraines

Endometriosis

TMJ- Clenching of the jaw

Any active infections
If yes, please list: _____

other health concerns: _____

Have you ever used Accutane? Yes No If yes, when? _____

Do you have any of the following conditions? Check all that apply.

What topical medications are you currently using or have used in the last 6 months?

Retin-A Differin Aczone Others (please specify): _____

What oral medications are you presently taking? _____

What vitamins or herbs are you presently taking? _____

Have you had recent tanning or sun exposure that changed the color of your skin? Yes No

Do you use sunscreen? Yes No How often? _____

Do you use any self-tanning lotions? Yes No

Do you form thick or raised scarring from cuts or burns? Yes No

Do you develop hyperpigmentation (darkening), hypopigmentation (lightening), or marks after physical trauma? Yes No

FEMALE MEMBERS/GUESTS

Are you pregnant or trying to become pregnant? Yes No

Date of last menstrual period: _____