LASER REJUVENATION

Botox & Dermal Filler Consultation Information

Date: _______________

Patient Name: ____ Date of Birth: ___/___/___

Address: _____________________________________ City: ____________________ State: ________ Zip: ________

Home Phone: _____________________________________ Cell Phone: _____________________________________

EMail: ____ Work Phone: _______________________

Name of Employer: _______________________________________ Occupation: ____________________________

Emergency Contact Person: ____

Relationship: ____ Phone: _____________________________________

How did you hear about us? ____

Please indicate areas of interest:

Laser Hair Removal

Area of Interest	Hair Color	Current Method of Hair Removal Frequency & Date of Last Use

Body Contouring/Inch Loss

Area of Interest	Area of Interest	Area of Interest
❑ Thigh ❑ Buttocks	❑ Abdomen ❑ Hips	❑ Arms ❑ Lower Back/Love Handles

Skin Rejuvenation (Check all that apply)

Skin Tone	Firmness & Elasticity	Texture
❑ Uneven Skin Color ❑ Sun Damage ❑ Age Spots ❑ Freckles ❑ Broken Capillaries ❑ Rosacea	❑ Wrinkles: __Deep __ Fine ❑ Lip Lines ❑ Crows Feet ❑ Laugh/Smile Lines ❑ Loss of Firmness/Elasticity	❑ Leathery Texture ❑ Acne Scarring ❑ Large Pores ❑ Blackheads ❑ Dry/Rough Skin ❑ Acne Breakouts

For Staff Only: (Recommendations: Discussion with provider)

_____ 1. Treatment options: (no alternative for Botox, other dermal fillers or plastic surgery)

_____ 2. Client expectations: (understand need for multiple treatments, after care, possible side effects, etc.)

_____ 3. Physician consultation before Botox or filler treatment initiated

_____ 4. Full treatment schedule process (waiting period between treatments, expected results)

_____ 5. Verify allergies (NO ALLERGY TO LIDOCAINE)

_____ 6. Possible side effects (pain, redness, swelling, bruising) and expected healing if side effect occurs

_____ 7. Importance of sun exposure avoidance and use of broad-spectrum SPF 30 (zinc oxide or titanium dioxide)

_____ 8. Cost of treatments (payment schedule, cost of multiple treatments versus single treatment payments)

_____ 9. Importance of post care instructions/procedures.

HAVE PHOTOS BEEN TAKEN TODAY? Yes: _______ No: _______

Staff Comments:

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I agree that the information listed above has been reviewed and presented with my clear understanding of what this procedure involves. All of my questions have been addressed to my satisfaction.

Signature: ____ **Date:** ____________________

Witness: ____ **Date:** ____________________