FACE sarah hamilton

PATIENT INTAKE FORM

Patient Name _____ DOB _____ Today's date _____

Address _____ City _____ State _____ Zip _____

Home (_____) _____ Cell (_____) _____ Cell Phone Carrier _____

Primary contact number (please circle): (H) (C) Email _____

Emergency Contact _____ Relation _____ Phone (_____) _____

Would you like to receive future monthly emails for promotional events, discounts, and specials from Sarah Hamilton FACE? (Y) ___ (N) ___ Please note: your email address is used strictly for our communication with you and will not be given out.

Do you have a Brilliant Distinctions account? _____ If yes, what is your password? _____

How did you hear about us?

Website/Internet ____ Social Media____ The Splash ____ The Inlander ____ Other (please specify) _____

Referred by a Patient? ____ *Name _____

Which concerns apply to you? Please circle all that apply.

Wrinkles	Scarring	Dull skin	Clogged pores
Skin laxity	Lip lines	Uneven skin tone	Under eye
Volume loss	Brown spots	Excessive oiliness	Skin texture

Other: _____

Are you pregnant or breast feeding? _____

Do you have any neuromuscular or autoimmune diseases? (Y) __ (N) __ List: _____

_____

Do you have any allergies? (Y) ____ (N) ____ Please list: _____

Allergic to latex? (Y) ____ (N) ____

Do you take Aspirin, Advil, Motrin, Ibuprofen, fish oils or anti-inflammatory meds more than once a week? (Y) ____ (N) ___
If yes, please explain:

_____

List all medications you are taking including antibiotics (prescription and over the counter): _____

_____

Do you have any allergies to medications? (Y) ___ (N)____ If yes, please specify and state type of reactions:

_____

Have you ever had any of the following Injectables or implants: (please circle)

Botox Dysport Juvederm Voluma Restylane Sculptra Other: _____

PATIENT'S SIGNATURE:

To the best of my knowledge, the information provided above is true and accurate.

_____ _____

Patient's Signature Date

_____

Please Print Your Name

_____ _____

Provider's Signature Date