Vibrance medical spa

Patient Information

General Information

Name: _____ Today's Date: _____

Address: _____

City, State, Zipcode: _____

Home Phone: _____ Cell Phone: _____

Email: _____ May we send **text** appt. reminders? ☐Y ☐N

May we send you emails relating to our specials & events? ☐Y ☐N

Date of Birth: _____

Occupation: _____ Referred by: _____

Emergency Contact: _____ Relationship: _____

Skin History

☐ Acne/Acne scarring
☐ Large Pores
☐ Fine Lines & Wrinkles
☐ Skin Laxity
☐ Skin Texture
☐ Unwanted Hair
☐ Dry Skin
☐ Oily Skin
☐ Melasma or Hyperpigmentation (dark spots)
☐ Rosacea or redness/flushing of the skin

How long have you had these concerns? _____

Do you feel that your condition is worsening? ☐Y ☐N

Have you ever been treated for this?

If yes, please explain: _____

Are you currently using medication for a skin condition?

☐ Accutane ☐ Retin-A ☐ Hydroquinone or bleaching agent ☐ Antibiotic: _____

Do you get cold sores or fever blisters? ☐Y ☐N

Do you form thick or raised scars (keloid)? ☐Y ☐N

Do you develop hyperpigmentation? ☐Y ☐N ☐ I don't know

When were you last exposed to direct sun or a tanning booth? _____

Do you use self-tanning products? ☐Y ☐N

Are you planning a vacation in the sun in the next 3 months? ☐Y ☐N

Have you ever used any of the following?

☐ Depilatories ☐ Shaving ☐ Waxing ☐ Stringing ☐ Tweezing

Do you get facials? ☐Y ☐N

Have you ever had skin acid peels? ☐Y ☐N

Have you ever had Microdermabrasion? ☐Y ☐N

What skincare products do you currently use?

_____

Do you wear foundation/face makeup? ☐Y ☐N

If yes, what product/brand are you using? _____

Have you ever had treatment for brown lesions or sunspots? ☐Y ☐N

Have you ever had Botox or Filler treatments? ☐Y ☐N

Personal History:

Do you smoke? ☐Y ☐N If yes, how many per day? _____

Do you consume alcohol? ☐Y ☐N

Do you exercise regularly? ☐Y ☐N

Do you wear contact lenses? ☐Y ☐N

Cosmetic History:

List all (or last) laser and/or injectables such as Botox, Restylane, Radiesse, collagen, fat or other:

Date Area Any Adverse Reactions

_____

_____

_____

Medical History:

Are you currently under the care of a physician? ☐Y ☐N _____

Do you have any of the following conditions?

☐ Arthritis	☐ Diabetes	☐ HIV/AIDS
☐ Any active infection	☐ Epilepsy or seizures	☐ Neurological disorder
☐ Bleeding disorders	☐ Heart Disease	☐ Sensitive teeth
☐ Bruising	☐ Hepatitis	☐ Skin cancer or moles
☐ Cancer	☐ Herpes simplex	☐ Skin injury
☐ Chest Pain	☐ High blood pressure	☐ Vision deficits
☐ Dark spots from pregnancy	☐ Hormone imbalance	☐ Thyroid disease

☐ Other: _____

Do you have allergies to any of the following:

☐ Topical skin care products/ingredients ☐ Anesthesia ☐ Latex ☐ Foods ☐ Plants

☐ Medications: _____

Do you take any of the following:

☐ Accutane
☐ Antibiotics
☐ Anti-Depressants
☐ Appetite suppressants
☐ Aspirin or Ibuprofen
☐ Blood thinners
☐ Cortisone or steroids
☐ Hormone/contraceptives
☐ Insulin
☐ Sedatives
☐ Thyroid medication
☐ Other:_____

Are you taking supplements or vitamins? (St John's Wort, Vitamin E, Fish Oil) ☐Y ☐N

List all surgeries:

Date	Procedure	Surgeon

Do you have any issues bruising or bleeding? ☐Y ☐N

Have you ever had an issue with your nerves and muscles? (Strokes, Bell's palsy, nerve injury, etc.)

Do you need to take antibiotics before procedures such as dental? ☐Y ☐N

Do you suffer from any neurological disorders? (myasthenia graves, MS, Lambert-Eaton Syndrome, ALS)

Do you have a pacemaker or other implantable device? ☐Y ☐N

<u>For Female Patients</u>

Are you pregnant or trying to become pregnant? ☐Y ☐N
Are you breastfeeding? ☐Y ☐N
Are you taking birth control? ☐Y ☐N
Do you have regular periods? ☐Y ☐N

I have answered the questions contained in this questionnaire to the best of my knowledge.
I understand it is my responsibility to inform my practitioner of my current health conditions while seeking treatment as a patient. I will update this information as it occurs if there are changes to my health in between treatments.

Signature: Date:

Patient Photography Release Form

It is necessary that we take pre and post treatment photographs of our patients in order to track progress and view treatment results.

This consent permits photography of me or parts of my body related to the procedure(s) that have been or will be performed. This consent authorizes Vibrance Medical Spa to take photographs for the documentation of my medical progress. The "Medical Care Only" consent portion is required in order to have any procedure(s) with Vibrance Medical Spa.

Please check one of the following boxes, and initial at the end of the paragraph.

YES NO

☐ ☐ **Medical Care Only:** (Required) Photographs taken of me or parts of my body can be used for the purpose of documenting my medical care. _____ (Initial)

YES NO

☐ ☐ **Educational Purposes:** Photographs taken of treatment areas can be used to educate others regarding treatments. I understand that if I consent for photography related to the procedure(s) for "education purposes" that my photographs may be used for the in-office photo album ONLY and no other forms of marketing without further consent. _____ (Initial)

YES NO

☐ ☐ **Website:** Photographs taken (of treatment area) can be used on the website in order to inform others about methods and results.

_____ (Initial)

YES NO

☐ ☐ **Social Media:** Photographs taken (of treatment area) can be used on our Facebook, Instagram or other social media websites in order to inform others about methods and results.

_____ (Initial)

I certify that I have read the above photography release form and fully understand its terms.

_____

Signature of Patient or Legal Guardian

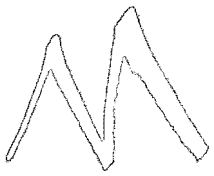
_____

Patients Name or Legal Guardian Printed

_____

Date

VIBRANCE MEDICAL SPA
Spa Etiquette and Policies



RETURNS

We have a 30 day return policy; however, if you return your product within the first 2 weeks of your purchase, you will receive a full refund, if returned after 2 weeks, you will receive store credit. No returns after 30 days.

NURSE/AESTHETICIAN CANCELLATION AND LATE ARRIVAL POLICY

We understand that situations arise for which you must cancel your appointment. As a courtesy to our staff, as well as other clients, we request a 24 HOUR CANCELLATION notice. If it is cancelled less than 24 hours you may be subject to a $50 fee for each 30 minute increment of your scheduled appointment.

All spa appointments have been designed to allow appropriate time for full enjoyment of each service. Your late arrival may limit our ability to offer the fullest possible experience. Please be aware that late arrivals will not be afforded extension of scheduled treatment(s). Treatments will be rendered only for the remainder of the scheduled appointment time and you will be responsible for payment of the service in full.

COOLSCULPTING CANCELLATION POLICY

In order to schedule a CoolSculpting treatment we require that you pay a $500 booking fee, the remaining balance is paid at the time of treatment. Please note that the booking fee is non-refundable if you do you cancel less than 48 hours of your scheduled appointment.

NO SHOWS

The reservation of an appointment indicates that we have reserved the service time for you and therefore had to decline other customer business. If you do not show for your appointment you may be subject to a $50 fee for each 30 minute increment of your scheduled appointment.

CELL PHONE

To preserve the serenity of the spa we kindly ask you to turn off/silence your mobile phone upon arrival.

CHILDREN IN SPA

We request that young children do not accompany you for your appointments. This allows for a relaxing environment for our other guests as well as a safer environment for you during treatment time. Thank you for understanding.

PETS

Vibrance Medical Spa is associated with Freed Plastic Surgery Center. Dr. Freed has an on-site operating room that requires strict regulations on having animals in our facility. No animals are allowed unless it is a service dog that assists you with a disability.

I consent to the spa policies listed above. I am satisfied with the explanations.

Patient Name
(Please Print):_____

Patient
Signature:_____ Date:_____

Witness
Signature:_____ Date:_____