TWIN PORTS
Dermatology

AESTHETIC LOUNGE INTAKE FORM

-PLEASE PRINT & FILL OUT THE FORM COMPLETELY-

PATIENT INFORMATION

First Name:		Last Name:	Middle Initial:
Prefers to be called:		Ethnic Background:	Birth Date: / /
Pronouns ☐ He/him ☐ She/her ☐ They/them	Gender:	Occupation:	
	Phone #: ( )	Email:	
	Emergency Contact Name:	Emergency Contact Phone #: ( )	
Street Address:			P.O. Box:
City:		State:	ZIP Code:
How did you hear about us:		What is the main reason for your visit today:	

SKIN ISSUES & CONCERNS

Check all that describe your skin:

☐ Oily ☐ T-Zone/Combination ☐ Eczema ☐ Hyperpigmentation
☐ Normal ☐ Sensitive ☐ Psoriasis ☐ Melasma
☐ Dry ☐ Rosacea ☐ Resilient ☐ Other:_____

CURRENT SKINCARE PRODUCTS

What skincare products are you currently using? **Write the product brand on the line behind every box you select.**

☐ Cleanser_____ ☐ Moisturizer_____ ☐ Serum_____ ☐ Body Care_____
☐ Exfoliant/Scrub_____ ☐ SPF_____ ☐ Retinol_____ ☐ Sunless Tanner_____
☐ Toner_____ ☐ Eye Cream_____ ☐ Soap_____ ☐ Other_____

SKIN & THE SUN

Check one that best describes how your skin reacts to the sun.

☐ I always burn.
☐ I always tan.
☐ I usually burn and sometimes tan.
☐ I usually tan and sometimes burn.
☐ Other:_____

COSMETIC TREATMENTS

Have you had any cosmetic treatments/procedures?

☐ Facial ☐ Facial Resurfacing
☐ Microdermabrasion ☐ Photo Facial/IPL/BBL
☐ Chemical Peel ☐ Facial Surgery
☐ Laser Hair Removal ☐ Plastic Surgery
☐ Microneedling/SkinPen ☐ Other:_____
☐ Botox/Injections/Fillers _____

FOR INJECTABLE PATIENTS ONLY

Do you have any of the following:

☐ Hypersensitivity Reactions ☐ Neuromuscular Disorders ☐ Breathing Difficulties ☐ Weakness
☐ Cardiovascular Disease ☐ Swallowing Difficulties ☐ Facial Inflammation ☐ Atrophy

SIGN UP FOR REWARDS PROGRAMS

Allē | *alle.com*
Botox, Juvederm Fillers, DiamondGlow, Latisse, Skin Medica, and CoolSculpting

Aspire | *aspirerewards.com*
Dysport, Galderma Fillers, and Sculptra

ColorScience | *colorscience.com*
All ColoreScience products

MEDICAL SPA HEALTH HISTORY

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PERSONAL HEALTH HISTORY

Do you have a history of the following:

☐ Scarring ☐ Hyperpigmentation ☐ Keloids ☐ Herpes/Cold Sores

Glasses of water consumed per day:

Caffeinated beverages consumes per day:

Do you have any significant illness or have you in the past:

Have you experienced any adverse reactions to treatments or products in the past? If so, please describe: _____

_____

HORMONES - FOR FEMALES ONLY

☐ Yes ☐ No Are you taking birth control or estrogen?
☐ Yes ☐ No Do you get regular periods?
☐ Yes ☐ No Are you on or expecting a menstrual cycle?
☐ Yes ☐ No Are you going through menopause?
☐ Yes ☐ No Are you pregnant or nursing?
☐ Yes ☐ No Have you given birth?
If yes, when was your last child born: _____

HORMONES - FOR MALES ONLY

☐ Yes ☐ No Do you have hormonal imbalance issues?
☐ Yes ☐ No Do you get ingrown hairs after shaving?

When was the last time you shaved:

MEDICATION, VACCINATION, & ALLERGY HISTORY

Please list all prescription and over-the-counter medications you are currently taking (i.e. pain relievers, vitamins/supplements, or baby aspirin): _____

_____

_____

Please list all known allergies: _____

_____

MEDICAL CONDITION HISTORY

Do you have a history of the following:

☐ Migraines
☐ Communicable Disease
☐ Metal Implants/Piercings
☐ Pacemaker
☐ Epilepsy/Seizures
☐ History of Accutane or Retin A
☐ Use of Blood Thinners, Aspirin, or NSAIDS
☐ Fainting
☐ Diabetes
☐ Heart Issues
☐ Other: _____

SIGNATURES

Initials: _____ I have read Twin Ports Dermatology's Patient Financial Policy. I know of the required 48-hour notice for cancellation/rescheduling and failure to do so will result in a $50 fee.

Initials: _____ I understand I need to keep a credit card on file to schedule all spa appointments.

Initials: _____ I have read Twin Ports Dermatology's HIPAA Acknowledgement Form.

Initials: _____ I have read Twin Ports Dermatology's Notice of Privacy Practices. I know I can ask for a copy at any time.

Initials: _____ I understand cosmetic treatment results vary and are not guaranteed.

Initials: _____ I understand refunds are not issued for the cosmetic service(s) performed.

Initials: _____ I understand refunds on retail product must be returned within 30 days of purchase for an exchange or Med Spa credit only.

The above information is true to the best of my knowledge.

Patient/Guardian Signature: _____ ***Date:*** _____