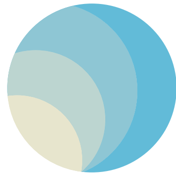

TWIN PORTS
Dermatology

MEDICAL SPA 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
☐ Normal
☐ Dry
☐ T-Zone/Combination
☐ Sensitive
☐ Rosacea
☐ Eczema
☐ Psoriasis
☐ Resilient
☐ Hyperpigmentation
☐ Melasma
☐ Other:____________

CURRENT SKINCARE PRODUCTS

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

☐ Cleanser____________
☐ Exfoliant/Scrub____________
☐ Toner____________
☐ Moisturizer____________
☐ SPF____________
☐ Eye Cream____________
☐ Serum____________
☐ Retinol____________
☐ Soap____________
☐ Body Care____________
☐ Sunless Tanner____________
☐ 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
☐ Microdermabrasion
☐ Chemical Peel
☐ Laser Hair Removal
☐ Microneedling/SkinPen
☐ Botox/Injections/Fillers
☐ Facial Resurfacing
☐ Photo Facial/IPL/BBL
☐ Facial Surgery
☐ Plastic Surgery
☐ Other:____________
____

FOR INJECTABLE PATIENTS ONLY

Do you have any of the following:

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

-PLEASE PRINT & FILL OUT THE FORM COMPLETELY-

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 consumed 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:*** ______