TWIN PORTS
Dermatology

# MEDICAL SPA PICO 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<br>☐ He/him<br>☐ She/her<br>☐ 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: | |

## GOALS

☐ Yes ☐ No Do you want to fade your tattoo?
☐ Yes ☐ No Do you want to remove your tattoo?
☐ Yes ☐ No Are you working with a tattoo artist?
If yes, where:_____
If yes, who:_____
☐ Yes ☐ No Do you know how laser tattoo removal works?

When did you get the tattoo we are working on:

## MEDICAL HISTORY

Do you have a history of the following:

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

## PERSONAL HEALTH HISTORY

☐ Yes ☐ No Do you use a tanning bed or self-tanners?
If yes, how often:_____
☐ Yes ☐ No Do you smoke?
If yes, how often:_____
☐ Yes ☐ No Do you exercise?
If yes, how often:_____
☐ Yes ☐ No Are you pregnant or nursing?
**How many glasses of water do you drink daily?** _____

## 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:*** _____