



PATIENT INFORMATION

Date of Birth: _____ Today's Date: _____
 First Name: _____ Middle Name: _____ Last Name: _____
 Address: _____
 City: _____ State: _____ Zip Code: _____
 Home #: _____ Cell #: _____
 Preferred Phone (circle one): Home/Cell May we leave voicemails/text this #?
 Email Address: _____
 Emergency Contact: _____ Phone #: _____
 Marital Status (circle one): Single Married Widowed Legally Separated Divorced
 Race (circle one): African American American Indian or Alaskan Native Asian
 White Native Hawaiian or other Pacific Islander Other
 Ethnic Group (circle one): Hispanic or Latino Not Hispanic or Latino
 Unknown Unspecified

MEDICAL HISTORY

Do you, or have you ever had any of the following conditions? Circle all that apply.

Accutane Use - if yes, date:	Infection (Active) Keloid / Hypertrophic Scars
AIDS/HIV	Kidney Disease
Anemia	Liver Disease
Arthritis	Lupus
Autoimmune Disorder	Melanoma- if yes, area / date: _____
Asthma	Mental Disorder / Illness
Bleeding Disorder	Neuromuscular Disorder
Blood Transfusion	Nervous Disorder
Blood Disease	Photosensitive Condition
Cancer (Chemo or Radiation)	Pigmentation Disorder
Claustrophobia	Psoriasis
Cosmetic Injectables - if yes, date: _____	Respiratory Issues
Depilatory Creams - if yes, date: _____	Skin Disease - if yes, type / date: _____
Diabetes	Skin Cancer - if yes, type / date: _____
Dizziness	Sinus Issues
Epilepsy / Seizures	Stomach Problems Stroke
Eczema	Tattoos - if yes, where: _____
Heart Disease	Tetracycline Use - if yes, date: _____
Hepatitis	Vitaligo
Herpes Simplex - if yes, date: _____	Waxing / Tweezing - most recent date:
Hormone Replacement Therapy	_____
High Blood Pressure	



MEDICATIONS

List all medications you are currently taking (oral or topical medications including aspirin):

ALLERGIES

Medication Allergies:

Cosmetic Allergies:

Latex Allergy:

Food Allergies/ Other:

HAVE YOU USED OR ARE CURRENTLY USING THE FOLLOWING

- Yes No Retin-A, Renova, Retinoic Acid Products
- Yes No Accutane/ Isotretinoinm
- Yes No Sotret, Claravis, Amnesteem, Absorica, Epuris, Isotroin
- Yes No Prescription Acne Medications
- Yes No Birth Control Pills
- Yes No Steroids
- Yes No Chemotherapy
- Yes No Radiation
- Yes No Pacemaker/ Internal Defibrillator



PREVIOUS PROCEDURES: IF YES, DATE/AREA

- Yes No Chemical Peels
- Yes No Superficial Metal or Other Implants
- Yes No Injectables / Fillers
- Yes No Tattoo / Permanent Makeup
- Yes No Waxing / Hair Removal
- Yes No Facial Surgery
- Yes No Laser Surgery
- Yes No Microdermabrasion
- Yes No Lesion / Mole Removal
- Yes No General Surgery

ARE YOU CURRENTLY

- Yes No Pregnant
- Yes No Trying to become Pregnant
- Yes No Breastfeeding
- Yes No Taking Blood - Thinners/ Aspirin
- Yes No Tanning / Using Self-Tanners

HAVE YOU EVER HAD

- Yes No Cold sores / Herpes / Fever Blisters / Shingles
If yes, how frequently? Circle one.
 - Less than 1 per year
 - 1-3 per year
 - 3-5+ per year

ARE YOU CURRENTLY USING/ HAVE USED IN THE LAST 3 MONTHS

- Yes No St. John's Wart
- Yes No Amniodarone
- Yes No Tetracycline Antibiotics
- Yes No Anti-Coagulants
- Yes No Cold Medications
- Yes No Oral/ Topical Retinoids
- Yes No Oral/Topical Steroids



SUN HISTORY AND LIFESTYLE: How often do you?

- | | | | | | | | | |
|-------------------------------|--------------------------|------------|--------------------------|--------------|--------------------------|--------|--------------------------|-------|
| Work Outside | <input type="checkbox"/> | Frequently | <input type="checkbox"/> | Occasionally | <input type="checkbox"/> | Rarely | <input type="checkbox"/> | Never |
| Use Sunscreen | <input type="checkbox"/> | Frequently | <input type="checkbox"/> | Occasionally | <input type="checkbox"/> | Rarely | <input type="checkbox"/> | Never |
| Use Tanning Beds | <input type="checkbox"/> | Frequently | <input type="checkbox"/> | Occasionally | <input type="checkbox"/> | Rarely | <input type="checkbox"/> | Never |
| Smoke or Use Tobacco Products | <input type="checkbox"/> | Frequently | <input type="checkbox"/> | Occasionally | <input type="checkbox"/> | Rarely | <input type="checkbox"/> | Never |

YOUR CURRENT HOME SKINCARE REGIMEN

Cleanser _____
Toner _____
Moisturizer _____
Eye Cream _____
Exfoliator _____
Sunscreen _____
Makeup _____
Other _____



I, _____ agree that the information above is correct and true to the best of my knowledge. I understand that this information will directly affect the outcome and results of my treatments at The Southern Skin and Beauty Bar.

Signature _____

Printed Name _____

Date _____

CANCELLATION POLICY

At The Southern Skin and Beauty Bar, we understand that situations arise and appointments need to be cancelled. To provide the best in customer care for all of our valued clients, we require a minimum 24-hour cancellation notice. Clients that do not honor their scheduled appointment will be charged a cancellation fee as follows:

More than 24-hour notice: Service will be cancelled at no charge

Less than 24-hour notice: 50% of the service will be charged

Failure to show without notice or same-day cancellations: 100% of the service will be charged

There is a \$200 non-refundable deposit for Botox/ Filler appointments. This \$200 will be directly applied to the procedure if the appointment is kept. If said appointment is cancelled in less than 24 hours, or there is failure to show without notice, the \$200 fee will be kept by The Southern Skin and Beauty Bar.

Payment of cancellation fee must be paid before a new appointment can be scheduled. This cancellation policy allows us the time to inform our stand-by clients of any availability.

Thank you for your cooperation in this matter and your consideration for other clients of The Southern Skin and Beauty Bar.

I have read and understand this cancellation policy, and I agree to be charged the cancellation fee for any infraction of this cancellation policy.

Signature _____

Printed Name _____

Date _____



HIPAA CONSENT FORM

Patient Name: _____

Date of Birth: _____

Date: _____

Consent for Release of Medical and Financial Information to FAMILY MEMBERS

I, _____ authorize The Southern Skin and Beauty Bar and its staff to use and disclose my medical and/or financial information to the following person(s):

Name: _____

Phone: _____

Relationship: _____

Name: _____

Phone: _____

Relationship: _____

No one

Consent to Photograph

The Southern Skin and Beauty Bar may choose to take photographs of me to be part of my medical record for purposes of comparison before and after certain treatments, or for teaching purposes. I agree that photographs may be taken during the procedure and these photographs remain the property of The Southern Skin and Beauty Bar.

X _____ Initialed by Client (or Parent/ Guardian, if client is a minor)

Consent to Photograph for Social Media

The Southern Skin and Beauty Bar may choose to take photographs of me to be part of their social media accounts. I agree that appropriate and tasteful photographs may be used as posts on social media accounts. This does NOT pertain to minors.

X _____ Initialed by Client



SKIN TYPE CLASSIFICATION QUESTIONNAIRE

SCORE		0	1	2	3	4
	What is the natural color of your hair?	Sandy red	Blond	Chestnut, dark blond	Dark brown	Black
	What is the eye color?	Light blue, Gray, Green	Blue, Gray, Green	Brown	Dark Brown	Brownish Black
	What is the color of sun unexposed skin areas?	Reddish	Very pale	Pale with beige tint	Light brown	Dark brown
	How many freckles on unexposed skin areas?	Many	Several	Few	Incidental	None
	What happens when you are in the sun TOO long without sunblock?	Painful redness, blistering, peeling	Blistering followed by peeling	Burns, sometimes followed by peeling	Rarely burns	Never had a problem
	How well do you turn brown?	Hardly or not at all	Light color tan	Reasonable tan	Tan very easily	Turn dark very quickly
	Do you turn brown within one day of sun exposure?	Never	Seldom	Sometimes	Often	Always
	How does your face respond to the sun?	Very sensitive	Sensitive	Normal	Very resistant	Never had a problem
	When did you last expose yourself to the sun or artificial sun treatments?	More than 3 months ago	2-3 month ago	1-2 months ago	Less than 1 month ago	Less than 2 weeks ago
	Do you expose the area to be treated to the sun?	Never	Hardly ever	Sometimes	Often	Always
	TOTAL					

- 00-07 points = Skin type I
- 08-16 points = Skin type II
- 17-25 points = Skin type III
- 25-30 points = Skin type IV
- 30-40 points = Skin type V & VI