Patient Introduction

CREEKSIDE
DAY SPA SKIN & LASER CENTER
ESTABLISHED 1998

MICHAEL B. STEVENS • MD • PhD • FACS
BOARD CERTIFIED PLASTIC SURGEON

Name: _____
(First) *(Last)* *(Middle)*

Date of Birth: ___/___/___ Age: _____ Wedding Anniversary: ___/___/___

Occupation: _____

Address: _____
(Number) *(Street)* *(City)* *(State)* *(Zip)*

May we contact you by email? ☐ Yes ☐ No

Email Address: _____

Primary Contact Number: _____ Secondary Number: _____

Emergency Contact: _____
(First & Last Name) *(Phone)* *(Relation)*

How did you hear about us? _____

_____

Authorization for Treatment and Financial Disclosures

I authorize treatment for the person named above and agree to pay all charges for such treatments. I agree to pay all charges for me and members of my family at time of service. I authorize the release of any information regarding my treatment needed to resolve any billing dispute.

If unable to keep appointment CreekSide Day Spa Skin & Laser Center requires a 48 hour notice for any single treatment, and a 72 hour notice for any two or more treatments, including Permanent Makeup and Micro-Needling. If CreekSide Day Spa Skin & Laser Center is not notified prior to your appointment, there will be a $25.00 service charge per procedure. Friendly reminder, we have a no children & no cell phone policy.

(NO EXCEPTIONS) *Thank you for your understanding and consideration.*

Signature: _____ Date: _____

Confidential Medical Information

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Name: _____ Date: _____

Do you now have or have you ever had any of the following? *Please circle all that apply:*

Arthritis	Fainting	Pacemaker
Asthma	Fatigue/Sleep Disorder	Permanent Make-Up
Blood Clots	Fibromyalgia	Are You Currently Pregnant? (___weeks)
Blood Pressure H/L	Headaches	Rashes
Broken/Fractured Bones	Heart Condition	Sinus Problems
Cancer/Chemo	Hepatitis/TB/HIV	Spasms/Cramps
Chronic Pain	Herpes/Shingles	Sprains/Strains
Depression/Anxiety	Implanted Medical Devices	Spinal/Bone Problems
Diabetes	Jaw Pain/TMJ	Stroke
Digestive Disturbances	Lymphedema	Swelling
Dizziness	Nail/Skin Fungus	Tattoos
Easy Bruising	Numbness/Tingling	Varicose Veins
Epilepsy	Open Sores/Ulcers	Warts
		Wear Contacts

Other: _____

Do you have a history of Keloids or Hypertrophic Scars: ☐Yes ☐No

Do you tan: ☐Yes ☐No How: ☐Direct Sun ☐Tanning Bed ☐Spray Tan

Are you under the care of a physician: ☐Yes ☐No Last visit: _____

Dr. _____

Are you allergic to: ☐Milk ☐Apples ☐Grapes ☐Aloe Vera ☐Aspirin ☐Hydroquinone ☐Kojic Acid

Allergic to any medications and/or chemicals?: _____

Do you use/take: ☐Accutane ☐Aspirin ☐Blood Thinners ☐Retin-A
☐Other Rx skin topical products ☐Oral Rx medication

Others: _____

Have you recently had a: ☐Chemical Peel ☐Laser Resurfacing ☐Botox/Fillers If so when: _____

What products are you currently using on your skin?: _____

_____

Peel/Microdermabrasion Consent Form

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- Prior to receiving treatment, I have been candid in revealing any condition that may have bearing on this procedure, such as: pregnancy (if so, do not do treatment), recent facial surgery, allergies, tendency to cold sores/fever blisters, use of Retin-A, Accutane, or hormones.
- I understand there may be some degree of discomfort; i.e. stinging, pinpricking sensation, hotness, tightness of possible pigmentation.
- I understand there are no guarantees as to the results of this treatment, due to many variables, such as: age, condition of skin, sun damage, smoking, climate, etc. I understand I may, or may not, actually peel and that each case is individual.
- I understand this treatment is a cosmetic treatment and that no medical claims are expressed or implied.
- I understand that to achieve maximum results, I may need several treatments.
- I understand that although complications are very rare, sometimes they may occur and that prompt treatment is necessary. In the event of any complications, I will immediately contact the clinician who performed the treatment.
- I agree to refrain from tanning and tanning booths while I am undergoing treatment and 14 days following treatment.
- I understand that direct sun exposure is prohibited while I am undergoing treatment and that the use of sunblock protection with a minimum of SPF 35 is mandatory.
- I have not had any other peel treatments of any kind within 14 days of this treatment, with the exception of glycolic acid peels which can be performed once or twice a week. I understand I cannot have another treatment within 14 days of this treatment, whether the treatment is performed at this location or any other location.
- I consent to the administration of medication, and local topical anesthetics to be applied by or under the direction of Michael B. Stevens, MD, PhD, FACS.
- I understand that the practice of medicine is not an exact science and that the exact outcome of each treatment cannot be predicted with accuracy.
- I hereby agree to all of the above and agree to have this treatment be performed on me. I further agree to follow all post-peel care instructions as I am directed.

Client's Signature _____ Date _____

For Office Use Only

Peel _____ Initial _____	Peel _____ Initial _____
Peel _____ Initial _____	Peel _____ Initial _____
Peel _____ Initial _____	Peel _____ Initial _____
Peel _____ Initial _____	Peel _____ Initial _____
Peel _____ Initial _____	Peel _____ Initial _____
Peel _____ Initial _____	Peel _____ Initial _____
Peel _____ Initial _____	Peel _____ Initial _____
Peel _____ Initial _____	Peel _____ Initial _____