Patient Information and Medical History

Name:____ Date of Birth:_____________

Address:______________________________ City:________________State: _____ Zip:_______

Cell Phone #:_________________________ Home Phone #:_____________________________

Email Address:____

Employer:______________________________ Occupation:____________________________

Emergency Contact Name:____________________________ Phone Number:_______________

How Did You Hear About Us:____

Do We Have Permission To Use Your Photos For Educational Purposes:_______Yes_________No

Do We Have Permission To Post Your Photos To Social Media:___________Yes_____________No

Do We Have Permission To Post Your Photos To Our Website:___________Yes_____________No

Primary Physician:_____________________________ Dermatologist:____________________

Do You Have Any Allergies To Any Medications:_______________________________________

Do You Have Any Food Allergies:____

Do You Have A Latex Allergy:____

In The Past 6 Months Have You Had A Rash, Swelling, Peeling, Or Hives:_______Yes________No

If Yes Please Explain:____

What Medications, Vitamins, Or Supplements Are You Taking:_____________________________

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Are You Pregnant:______________________ Are You Nursing:___________________________

Are You Taking Or Have You Ever Taken Accutane:_______________________________________

Are You Using or Have You Ever Used Retin-A On Your Skin:_____________________________

Are You Using Or Have You Ever Used Renova On Your Skin:________________________________

Are You Using Or Have You Ever Used Hydroquinone on Your Skin:___________________________

What Skin Care Products Do You Currently Use:____

Do You Use A Daily SPF:______________________ If Yes What Grade:________________________

How Would You Describe Your Skin:_______Oily_______Dry_______Combination_______Sensitive

What Is Your Ethnic Background:____

When Was The Last Time You Were Exposed To The Sun Other Than Normal Exposure:__________

When Was The Last Time You Used A Self Tanner Or Had A Spray Tan:________________________

What Concerns You About The Overall Appearance Of Your Skin(Please Check All That Apply)

___Acne	___Acne Scarring	___Age Spots	___Aging Hands
___Aging Skin	___Blackheads	___Body Acne	___Broken Blood Vessels
___Broken Capillaries	___Brown Spots	___Cellulite	___Cysts
___Dehydrated Skin	___Dull Complexion	___Facial Hair	___Facial Veins
___Fine Lines	___Frequent Breakouts	___Hyperhidrosis	___Large Pores
___Loose Skin	___Loss Of Lashes	___Loss of Brows	___Melasama/Brown Patches
___Oily Skin	___Redness	___Rosacea	___Sagging Skin
___Scarring	___Skin Tags	___Skin Texture	___Spider Veins
___Stretch Marks	___Sun Damage	___Thin Lips	___Toenail Fungus
___Under Eye Circles	___Unwanted Fat	___Unwanted Hair	___Wrinkles

Are You In Good Health Overall:______Yes______________No_______________________Concerns

Are There Any Health Problems We Should Be Advised Of:___________________________________

Are You Currently Being Treated For ANY Medical Condition:________________________________

Do You Have Any Form Of A Herpetic Virus:____

If Yes When Was Your Last Outbreak:____

Do You Smoke:_______________Yes________________No________________________Frequency If Yes

Do You Have An Internal Pacemaker:____

Do You Have An Internal Defibrillator:____

Do You Have Any Implanted Surgical Devices:____

Please Check All That Apply:

___Allergies	___Asthma	___Arthritis	___Autoimmune Illness
___Bleeding Disorder	___Cancer	___Clotting Disorder	___Eczema
___Lung Disease	___Diabetes	___Hay Fever	___Heart Disease
___Hepatitis	___Herpes	___HIV/AIDS	___Lupus
___Menopause	___Mental Illness	___Photosensitivity	___Skin Cancer
___Stroke/TIA	___Melanoma	___Psoriasis	___Tuberculosis

I ATTEST THAT THE ABOVE INFORMATION TO BE TRUE, KNOWING THAT MY PROVIDER RELIES ON THIS INFORMATION TO PROVIDE SAFE AND EFFECTIVE TREATMENT.

Patient Signature:____Date:__________________________

Patient Name(Print):____

Relationship To Patient If Signer is Under The Age of 18:____

Provider Signature:____Date:__________________________

Doctor Signature:____Date:__________________________

Treatment Expectation Agreement

It is the goal of Indigo Laser and Aesthetics to offer effective and proven treatments to our clients. Your Indigo providers will do everything within the confines of safety and regulation to ensure that you receive a positive outcome from your treatment. Within those confines lies the knowledge that comes with years of experience and understanding that each client is a unique individual and will respond in a unique and individual manner. The following should be understood before beginning and completing any aesthetic treatment.

1. I understand that each person is unique and will respond in their own unique manner to any aesthetic treatment and that no degree of outcome is guaranteed.

2. I understand that healing time is unique and will vary with each individual and will be different with each individual treatment.

3. I understand that with the injection of neuromodulators as well as dermal fillers that there is a potential that I will need more of the product to achieve the outcome I wish to be desired and that the additional cost will be my responsibility.

4. I understand that it is my responsibility and obligation to inform Indigo Laser and Aesthetic of any concern I have post treatment within a timely manner.

5. I agree to meet with an Indigo Laser and Aesthetic provider if there are any concerns regarding the outcome of a treatment to review before and after photographs as well as reviewing the procedure and its limitations.

6. I understand that to achieve optimal results in nearly all aesthetic treatments, multiple treatments are typically required.

7. I understand that I will be required to submit a deposit for certain treatments including but not limited to, Ultra Femme 360, dermal fillers, BTL Body Sculpting and Skin Tightening and other treatments offered by Indigo. I understand that all terms of payment and financing will be discussed with me at the time of my consultation. I understand that this deposit is non-refundable.

8. I understand that if I am required to place a deposit due to non—compliance within the terms of the Indigo Laser and Aesthetic cancellation policy that this is a non-refundable deposit and will be deducted from my final bill if the appointment is kept but will be retained and be non-refundable if the appointment is missed or cancelled within 24 hours of my appointment time.

9. I have been thoroughly informed of all potential side effects as well as negative outcomes for the treatment or treatments that I have requested to be performed. I have signed all consents and treatment forms as required by Indigo Laser and Aesthetics.

______________________________________ __________________________

client name date

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client signature

______________________________________ __________________________

witness signature date