GLOWAESTHETICS
MEDICAL SPA + BEAUTY BOUTIQUE

PATIENT INFORMATION

Legal Name:	Date of Birth:
Preferred Name:	Preferred Pronouns: They/Them She/Her He/Him
Street Address	City, State:
Primary Phone:	E-mail:

How did you hear about us?

- ☐ Word of Mouth/Friend:
- ☐ Instagram
- ☐ Facebook
- ☐ Google
- ☐ Radio
- ☐ Print Ad
- ☐ Other

PRIMARY CARE PHYSICIAN

Name:	Phone Number:
City, State:	

PHARMACY INFORMATION

Name:	Phone Number:
City, State:	

EMERGENCY CONTACT

Name:	Relationship:
Phone Number:	

THE FOLLOWING AGREEMENT MUST BE SIGNED BY PATIENT, PARENT, AND/OR LEGAL GUARDIANS.
I assume full responsibility for and agree to prompt and full payment of all charges incurred by me (or the person for whom I am legally responsible).

Signature: Today's Date:

MEDICAL HISTORY

Please circle your response

Question			
Do you have a pacemaker or defibrillator?	NO	YES	
Do you suffer from 'photosensitivity" or extreme sensitivity to sunlight?	NO	YES	
Do you have a history of easy/excessive hyperpigmentation?	NO	YES	
Do you suffer from keloid scars?	NO	YES	
Do you suffer from seizures?	NO	YES	
Do you have metal implants?	NO	YES	If yes, where?
Do you wear contact lenses?	NO	YES	
Have you taken Accutane in the past 12 months?	NO	YES	
Have you used Retin-A or retinol in the past 12 months?	NO	YES	If yes, what brand and percentage?
Are you currently taking Coumadin (Warfarin), Aspirin or other blood thinners?	NO	YES	
Do you require antibiotics before procedures such as dental cleanings?	NO	YES	
Do you smoke or vape?	NO	YES	If yes, how frequently?
Do you drink alcohol?	NO	YES	If yes, quantity/week:
Have you ever had an adverse reaction to laser or cosmetic treatment?	NO	YES	If so, please list:
Are you allergic to any medications or foods?	NO	YES	If so, please list:
Are you taking vitamins or herbal preparations?	NO	YES	If so, please list:
Are you taking any prescription or over the counter medications?	NO	YES	If yes, please list:
Are you or might you be pregnant?	NO	YES	
Are you trying to become pregnant?	NO	YES	
Are you nursing?	NO	YES	

Have you ever had any problems with the following anesthetics?			
BLOCK (e.g. dental)	NO	YES	If so, please specify: Ineffective/Heart Palpitations/System Reaction/Other:
LOCAL:	NO	YES	If so, please specify: Ineffective/Heart Palpitations/System Reaction/Other:
TOPICAL:	NO	YES	If so, please specify: Ineffective/Heart Palpitations/System Reaction/Other:

Have you ever had any of the following? Please check all that apply.

▢ Active Skin Infection	▢ Arthritis	▢ Asthma	▢ Bleeding Disorders
▢ Blistering Sunburn	▢ Circulation Problems/Blood Clots	▢ Cold Sores/Shingles	▢ Collagen Disorder
▢ Diabetes	▢ Easy Bruising	▢ Eczema	▢ Endocrine/Hormonal Issues
▢ Eye Problems	▢ Fatigue	▢ Fibromyalgia	▢ Headache/Migraines
▢ Heart Condition	▢ Hepatitis	▢ High Blood Pressure ▢ Low Blood Pressure	▢ HIV/AIDS
▢ Insomnia/Sleeping Problems	▢ Joint Injury	▢ Permanent Makeup/Tattoo	▢ Circulation Problems/Blood Clots
▢ Psoriasis	▢ Recent Injury	▢ Skin Cancer	▢ Skin Injury
▢ Unusual Moles	▢ Varicose Veins	▢ Multiple Sclerosis	▢ Muscle Pain/Spasms
▢ Neurological Disorders	▢ Scleroderma	▢ Sensitive Teeth	▢ Vision Deficits
OTHER:			

SKIN HISTORY AND CONCERNS

Please list any products that irritate your skin:			
Have you had unprotected sun exposure or been in a tanning booth in the last two weeks?	NO	YES	
Do you use a self tanner?	NO	YES	If so, date of last application:
Have you used any of these hair removal methods in the last 6 weeks (please circle)?			
Shaving Waxing Electrolysis Laser Tweezing Depilatories			
What is your AM Skincare Routine?			
What is your PM Skincare Routine?			

ACKNOWLEDGEMENT OF PRACTICE POLICIES 2021

Please Initial Each

I understand I will receive a variety of treatments at GLOWAESTHETICS to include: facials, Hydrafacials, laser hair removal, chemical peels, skin resurfacing and neuromodulators and filler injections. I understand that depending on the treatment I select, I will be required to sign an informed consent specific to that treatment. I am fully aware that my condition is solely of cosmetic nature and the decision is based on my expressed desire to do so.	INITIALS:
I understand that my treatments at GLOWAESTHETICS require payment and the prices and fee structure for treatment have been explained to me. I may request a quoted price of the treatment and acknowledge the quoted price is the price for each individual treatment session unless otherwise specified in writing by GLOWAESTHETICS.	INITIALS:
I understand that the services often require more than one session for the best outcome. I further understand that the services offered by GLOWAESTHETICS are elective in nature and are not covered by health insurance. I agree to pay for the treatment according to the payment plan discussed. GLOWAESTHETICS accepts payment in the form of cash, check and major credit cards.	INITIALS:
All sales of skincare and makeup products are final. Unopened products may be returned with a receipt for a store credit within seven days. No returns for prepaid services or gift certificates.	INITIALS:
GLOWAESTHETICS and its providers will take before and after pictures of the treatments being performed on me.	INITIALS:
▢ I give GLOWAESTHETICS permission for my photos to be used in advertising and education ▢ I do not give GLOWAESTHETICS permission for my photos to be used in advertising and education	INITIALS:
I understand that all medical cosmetic treatments provided exclusively at GLOWAESTHETICS are elective by nature. I will not hold GLOWAESTHETICS, its owners, or its employees responsible for the results I experience. I understand that the results will vary.	INITIALS:
I further understand that GLOWAESTHETICS cannot prescribe an exact number of treatments to satisfy each individual's and the number of treatments I complete will be at my own discretion.	INITIALS:
I have read and fully understand all the terms of the ACKNOWLEDGEMENT OF PRACTICE POLICIES, all of my questions have been answered to my satisfaction and I agree to the terms of this content.	INITIALS:
Patients/Clients frequently request that we communicate with them by phone, voicemail, email or text. GLOWAESTHETICS respects your right to confidential communications about your protected health information. Since email and texting can be inherently insecure as a method of communication, we will only communicate with you by our HIPAA compliant texting application, OhMD. OhMD text messages, with your written consent will be sent to the phone number you provide to us. When you consent to communication with us by OhMD text messaging, you are consenting to OhMD text communications that are encrypted. There is always a chance messages may be intercepted by others if they have access to your phone. Therefore, you are agreeing to accept the risk that your protected health information may be intercepted by persons not authorized to receive such information when you consent to communicating with us through OhMD texting. GLOWAESTHETICS will not be responsible for any privacy or security breaches that may occur through OhMD text communications that you have consented to.	INITIALS:
By signing below, I consent to all communication, including but not limited to communication about my medical record and advice from my health care providers by text messages as well as appointment reminders.	
Patient Signature and Date:	
Patient Name (Print) and Date:	