



www.WeRejuvenate.com

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Patient Profile

Name _____ Date ____/____/____
DOB ____/____/____ Age _____ Height ____' ____" Weight _____# []Male []Female
Address _____ City/State _____ Zip _____
Home Phone _____-_____-_____ Cell Phone _____-_____-_____ Email _____
Emergency Contact _____ Phone _____-_____-_____ Relation _____
Occupation _____ How did you hear about us? _____

Medical History

Who is your general physician? _____ Phone: _____-_____-_____
List all medications (oral and topical) _____
List all herbs/vitamins you are taking _____
List all known allergies _____
List and date all surgeries _____

Do you wear contact lenses? []Y []N Are you pregnant or lactating? []Y []N
Do you take contraceptive pills? []Y []N Do you bruise easily? []Y []N
Are you sensitive to cold? []Y []N Are you taking hormones? []Y []N type_____
Are you taking antidepressants? []Y []N type_____ Do you drink caffeine? []Y []N amount _____
Do you have severe PMS? []Y []N Do you have irregular periods? []Y []N
Do you suffer from bloating? []Y []N Do you suffer constipation? []Y []N
Do you experience UTIs? []Y []N Any weight loss in the past year? []Y []N amount _____
Any weight gain in the past year? []Y []N amount _____ Do you drink water? []Y []N amount _____
Are you dieting? []Y []N type_____ Do you smoke? []Y []N amount _____
Do you take a blood thinner? []Y []N type_____ Do you take an anti-coagulant? []Y []N type_____
Have you ever used Accutane? []Y []N when?_____ Have you ever used Retin-A? []Y []N when?_____
Have you ever used Renova? []Y []N when?_____ Have you ever used Differin? []Y []N when?_____

Have you ever been diagnosed or treated for any of the following? (Check all that apply)

[]HIV/AIDS []Cold Sores []Fever Blisters []STDs []Skin Disorder
[]Hypertension []Cancer []Tumors []Ulcers []Liver Disease
[]Anemia []Heart Disease []Respiratory Disease []Vascular Disease []Diabetes
[]High Blood Pressure []Infections []Chronic Inflammation []Acute Inflammation []Kidney Failure
[]Intestinal Condition []Digestive Condition []Thyroid Disorder []Muscular Pain []Mental Disorder
[]Seizures []Melanoma []Hemophilia []Lupus []Tuberculosis
[]Epilepsy []Psoriasis []Dermatitis []Eczema []Keloid Scars

Have you ever received any of the following injections? (Check all that apply)

[]Botox® []Restylane® []Perlane® []Radiesse™ []Collagen
[]Fat []Silicone []Juvederm® []Sculptra™ []Gore-tex™

Have you ever had any of the following treatments? (Check all that apply)

[]Laser Resurfacing []Glycolic/AHA Peel []Phenol Peel []TCA Peel []PhotoFacial
[]Laser Hair Reduction []Laser Vein Reduction []Microdermabrasion []Sclerotherapy []Tattoo
[]Permanent Makeup []Face Lift []Liposuction []Other Cosmetic Surgery _____

Skin Profile

Please describe your skin (Check all that apply)

- | | | | | |
|---|--------------------------------------|---|---|---|
| <input type="checkbox"/> Oily | <input type="checkbox"/> Combination | <input type="checkbox"/> Dry | <input type="checkbox"/> Dehydrated | <input type="checkbox"/> Normal |
| <input type="checkbox"/> Congested | <input type="checkbox"/> Acneic | <input type="checkbox"/> Blackheads Present | <input type="checkbox"/> Whiteheads Present | <input type="checkbox"/> Sun-Damaged |
| <input type="checkbox"/> Acne Scarred | <input type="checkbox"/> Cystic | <input type="checkbox"/> Uneven/Spotchy | <input type="checkbox"/> Hyper Pigmented | <input type="checkbox"/> Hypo Pigmented |
| <input type="checkbox"/> Facial Veins Present | <input type="checkbox"/> Keratoses | <input type="checkbox"/> Cherry Angiomas | <input type="checkbox"/> Skin Tags | <input type="checkbox"/> Large Pores |
| <input type="checkbox"/> Thick | <input type="checkbox"/> Thin | <input type="checkbox"/> Firm | <input type="checkbox"/> Mature | <input type="checkbox"/> Wrinkled |
| <input type="checkbox"/> Small Pores | <input type="checkbox"/> Comedones | <input type="checkbox"/> Milia | <input type="checkbox"/> Florid | <input type="checkbox"/> Freckled |
| <input type="checkbox"/> Patchy Dryness | <input type="checkbox"/> Sallow | <input type="checkbox"/> Mclasma | <input type="checkbox"/> Sensitive | <input type="checkbox"/> Resilient |
| <input type="checkbox"/> Not Sure | <input type="checkbox"/> Jaundiced | <input type="checkbox"/> Reddish | <input type="checkbox"/> Broken Surface Capillaries Present | |

Please describe your eye color

- Blue Green Hazel Gray Light Brown Brown Dark Brown

Please describe your hair color

- Blonde Red Light Brown Brown Dark Brown Gray/Silver White

Please describe your skin tone

- Very Pale Pale Light Medium Olive Dark Very Dark

Do you do any of the following? (Check all that apply)

- Tan Outside Frequently Booth Tan Frequently Use Pore Strips Exercise Vigorously

Please list all skincare products that you are currently using

Please list all products that have caused an adverse skin reaction

Complaints

What are your general complaints?

- | | | | | |
|---|--|--|---|--|
| <input type="checkbox"/> Cellulite | <input type="checkbox"/> Body Fat | <input type="checkbox"/> Facial Fat | <input type="checkbox"/> Spider Veins | <input type="checkbox"/> Varicose Veins |
| <input type="checkbox"/> Broken Capillaries | <input type="checkbox"/> Thin Lips | <input type="checkbox"/> Loose Body Skin | <input type="checkbox"/> Loose Facial/Neck Skin | <input type="checkbox"/> Facial Hair |
| <input type="checkbox"/> Body Hair | <input type="checkbox"/> Wrinkles/Lines | <input type="checkbox"/> Acne | <input type="checkbox"/> Age Spots | <input type="checkbox"/> Hyperpigmentation |
| <input type="checkbox"/> Sun Damage | <input type="checkbox"/> Pre-Cancerous Cells | <input type="checkbox"/> Moles | <input type="checkbox"/> Rosacea | <input type="checkbox"/> Spots |
| <input type="checkbox"/> Scars | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Premature Aging | <input type="checkbox"/> Poor Circulation | <input type="checkbox"/> Texture |
| <input type="checkbox"/> Pore Size | <input type="checkbox"/> Facial/Neck Redness | <input type="checkbox"/> Stretch Marks | <input type="checkbox"/> Unwanted tattoos | <input type="checkbox"/> Other _____ |

Please describe your motivations and expectations for your treatments.

What procedures are you interested in?

- Laser Hair Reduction** Reduce unwanted facial and/or body hair
- Photo Rejuvenation** Reduce hyperpigmentation, sun damage, redness, and fine lines while improving skin texture
- Botox/Dysport** Reduce fine lines and wrinkles
- Facial Fillers** Fill wrinkles, folds and/or pits with injected dermal fillers
- Lip Fillers** Plump the lips with injected dermal fillers
- Laser Vein Reduction** Reduce broken capillaries and veins on the face and body
- Microdermabrasion** Improve skin texture and reduce the appearance of acne, fine lines and superficial pigmentation
- Chemical Peel** Reduce fine lines, reveal smoother skin and improve uneven skin tone
- Collagen Remodeling** Stimulate collagen plumping and dermal thickening, reduce fine lines and wrinkles
- LED Light Therapy** Accelerate healing, stimulate cell repair, reduce redness and acne-causing bacteria
- Mesotherapy** Dissolve targeted areas of fat with customized injections
- Laser Skin Resurfacing** Reduce wrinkles, scars, large pores and hyperpigmentation
- Photodynamic Therapy** Reduce acne, destroy pre-cancerous and damaged cells with levulonic acid and LED Light Therapy
- Skin Tightening**
- Body Contouring** Shape and contour specific body areas, reduce cellulite
- Tattoo Removal**
- Health, Wellness, & Nutritional Evaluation**
- hCG Weight Loss**
- Detoxification**

Authorization and Disclosure

I have fully disclosed my medical history and have completely and accurately answered all health related questions. I will alert Rejuvena of any changes to my health, medications and/or lifestyle as they occur.

I am undergoing treatment(s) of my own free will for cosmetic reasons. I understand that although every precaution will be taken to prevent complications, they can and sometimes do occur. I accept responsibility for any complication that may occur and hereby absolve and any Rejuvena associated person of any blame for any complications resulting from my treatments.

I authorize Rejuvena Health & Aesthetics, LLC to take photographs for the purpose of documenting and assisting all treatments.

Signature _____

Date _____

Voluntary Photo Release

I permit my "Before" and "After" photographs to be used in the Rejuvena Results Book for the benefit of other patients. I understand that all reasonable efforts will be made to protect my identity. Y N

Signature _____

Date _____

Payment Policies

The following policies and procedures regarding payments, refunds, credits and promotions are not negotiable and are to be understood and agreed to by all Rejuvena clients prior to treatment.

Forms of Payment

Rejuvena Health & Aesthetics, LLC accepts cash, check, credit card and certified funds as payment for retail and services. A credit card backup is required for checks over the amount of \$500. Any returned checks will incur a \$50 fee. Payment for services must be rendered before the services are performed.

Prepayment of Service

Any prepayment to secure special pricing is payable prior to expiration only and is non-refundable.

Gift Certificates

Gift certificates are issued by Rejuvena and are not applicable to any service provided by an independent physician or contractor. Gift Certificates may not be combined with any other promotion or discount and are applicable only to regularly priced services or packages. Promotional Gift Certificates are applicable only to the particular service indicated, and may not be substituted or redeemed for cash. Gift Certificates hold no cash value and expire one year from the date of issue.

Coupons and Discounts

Coupons must be presented at the time of service to receive any advertised discount. If coupon is not presented for any reason, the full price will be charged. Coupons are not valid after the expiration date listed.

Refunds and Credits

Payment for services rendered is non-refundable. Should management determine that a service did not achieve reasonable and expected results, credit may be issued for further services at the discretion of management. Credit issued by Rejuvena may not be applied to any independent physician or contractor service. Credit issued has no cash value.

The above-stated policies and procedures are non-negotiable and may be changed by management at any time. I understand and agree to all payment policies prior to receiving treatment.

Signature _____

Date _____