



HEALTH HISTORY

To ensure both the effectiveness and the safety of your treatment, please complete this health history as accurately as you can.

PERSONAL INFORMATION

Name _____ Date _____ DOB _____ Age _____

Address _____ Sex: ___ Female ___ Male

City _____ State _____ Zip Code _____

Home Phone _____ Work _____ Mobile _____ Other _____

Email: _____

How did you hear of us? Google Yahoo Dallas Voice Existing Patient Other _____

I AM INTERESTED IN: (Please check all that apply)

- HAIR REMOVAL
- SKIN TIGHTENING
- ROSACEA TREATMENT
- ACNE TREATMENTS
- CELLULITE TREATMENT
- OTHER, PLEASE SPECIFY _____
- SKIN REJUVENATION
- ACNE SCAR TREATMENT
- SUN DAMAGE / AGE SPOTS
- LASER LEG VEIN TREATMENTS
- PHOTOFACIAL
- SKIN CARE ADVICE / PRODUCTS
- MICRODERMABRASION/CHEMICAL PEELS
- FACIAL VEIN TREATMENTS
- TEETH WHITENING
- FAT/VOLUME REDUCTION

DO YOU USE SUNSCREEN YES NO IF YES, SPF # AND BRAND _____

WHEN YOU SUNBATHE, HOW DOES YOUR SKIN RESPOND?

- ALWAYS BURN, NEVER TAN
- USUALLY BURN, TAN WITH DIFFICULTY
- SOMETIMES BURN, TAN ABOUT AVERAGE
- ALMOST NEVER BURN, TAN VERY EASILY
- RARELY BURN, TAN EASILY
- NEVER BURN, ALWAYS TAN

MEDICAL HISTORY (Please circle your answer)

ACUTANE	YES	NO	HEPATITIS	YES	NO
ACNE	YES	NO	HIRSUTISM	YES	NO
ALLERGIES (drug or latex)	YES	NO	HIGH BLOOD PRESSURE	YES	NO
ARTHRITIS	YES	NO	HIV POSITIVE	YES	NO
AUTOIMMUNE DISORDER	YES	NO	KELOID SCARS (other scars)	YES	NO
BLOOD DISORDERS	YES	NO	KIDNEY DISEASE	YES	NO
CANCER (radiation therapy)	YES	NO	METAL PINS IN BODY	YES	NO
COLD SORES	YES	NO	MELANOMA	YES	NO
CONTACT LENSES	YES	NO	PACEMAKER	YES	NO
DERMATITIS/ECZEMA	YES	NO	RETIN A	YES	NO
DIABETES	YES	NO	PCOS (polycystic ovarian)	YES	NO
EPILEPSY	YES	NO	SKIN PIGMENTATION	YES	NO
GENETIAL HERPES	YES	NO	STD'S	YES	NO
HORMONAL IMBALANCE	YES	NO	Steroid or Hormonal Therapy	YES	NO
HEART CONDITION	YES	NO	SHINGLES	YES	NO
HEMOPHILIA	YES	NO	VITILIGO	YES	NO

Please Initial _____
Please fill out other side.

ADDITIONAL QUESTIONS:

1. ARE YOU CURRENTLY BEING TREATED FOR ANY CONDITIONS NOT LISTED? **YES NO** IF YES, PLEASE SPECIFY.

2. ARE YOU CURRENTLY TAKING ANY MEDICATIONS, INCLUDING HERBAL PREPARATIONS, OR MEDICAL PATCHES? **YES NO** IF YES, PLEASE SPECIFY.

3. DO YOU HAVE ANY ALLERGIES? **YES NO** IF YES, PLEASE SPECIFY.

4. HAVE YOU EVER USED (OR ARE CURRENTLY USING) RETIN A OR GLYCOLIC ACID? **YES NO** IF YES, PLEASE SPECIFY.

5. HAVE YOU EVER USED (OR ARE CURRENTLY USING) ACCUTANE? **YES NO** IF YES, PLEASE SPECIFY WHEN.

6. HAVE YOU EVER HAD A CHEMICAL PEEL? **YES NO** IF YES, PLEASE SPECIFY.

7. HAVE YOU HAD ANY LASER TREATMENTS? **YES NO** IF YES, PLEASE SPECIFY.

8. WHAT PRODUCTS ARE YOU CURRENTLY USING ON YOUR SKIN?

9. DO YOU HAVE ANY DENTAL OR ACRYLIC IMPLANTS, CROWNS OR BRIDGEWORK? **YES NO** IF YES, PLEASE SPECIFY.

10. DO YOU HAVE ANY TATTOOS OR PERMANENT MAKEUP IN THE AREA TO BE TREATED? **YES NO** IF YES, PLEASE SPECIFY.

11. DO YOU HAVE A PACEMAKER? **YES NO**

12. HAVE YOU EVER BEEN TREATED BY AN ENDOCRINOLOGIST (HORMONE IMBALANCE)? **YES NO** IF YES, PLEASE SPECIFY.

13. DO YOU SUNBATHE OR USE SELF TANNING LOTIONS OR USE TANNING BEDS? **YES NO** IF SO, THEN HOW OFTEN?

14. HAVE YOU EVER HAD GOLD THERAPY (USED FOR RHEUMATOID ARTHRITIS) **YES NO**

15. ARE YOU CURRENTLY PREGNANT OR TRYING TO GET PREGNANT? **YES NO YOU MUST INFORM US IF YOU BECOME PREGNANT DURING TREATMENTS.**

16. HAVE YOU HAD RESTYLANE, PERLANE, HYLAFORM OR BOTOX INJECTIONS IN THE AREA TO BE TREATED? **YES NO** IF YES, PLEASE SPECIFY.

17. DO YOU HAVE ANY PARTICULAR SKIN SENSITIVITIES? **YES NO** IF YES, PLEASE SPECIFY.

How soon would you like to begin treatments? Very Soon Near Future Today if Possible

Please sign below to indicate all the information on this for is accurate and complete.

Signature _____ Date _____

Patient Consent for Body Contouring/Skin Tightening treatment

Patient Name: _____

Procedure: Volume/Cellulite Reduction and Skin Tightening

I hereby authorize and direct any associates or assistants of Advanced Skin Fitness to perform Body Contouring/Skin Tightening treatment sessions on me. **Multiple treatments** will be required to achieve cosmetically acceptable results. In rare cases, patients may not experience any improvement even with multiple treatments. I specifically acknowledge that no guarantees or warranties have been made concerning the results of the procedure.

The following points have been discussed with me and I understand:
(please initial each statement)

_____ The potential benefits of Body Contouring & Skin Tightening treatment sessions.

_____ I understand that the radio frequency (RF) device is used for improving the appearance of cellulite and loose skin and is also used for fat/volume reduction. It may also be therapeutic for improving circulation and muscle aches in the treated areas. I understand there is a possibility of short-term effects such as reddening, blistering, scabbing, temporary bruising and temporary discoloring of the skin, as well as rare side effect such as scarring and permanent discoloration.

_____ Clinical results may vary depending on individual factors, including medical history, skin type, patient compliance with pre-post treatment instructions, and individual response to treatment.

_____ I understand that treatment involves a series of treatments and the fee structure has been fully explained to me.

_____ I am fully aware that my condition is of cosmetic concern and that the decision to proceed is based solely on my expressed desire to do so.

_____ I confirm that I am not pregnant at this time. It is my responsibility to let the technician know if I become pregnant during the treatment.

_____ I do not have a pacemaker or internal defibrillator.

_____ I do not have a history of systemic or local malignancies and do not have poorly controlled diabetes. I do not have history of lower extremity thrombus or blood clot formation, and am not photo allergic. I will inform the technician of any changes to my medical history during the course of VelaSmooth treatment sessions.

_____ I hereby authorize Advanced Skin Fitness or any associates to take pictures of the treated area to be used in my patient file.

_____ I understand that immediately following the radio frequency (RF) treatment, the treated area will appear as a red discoloration.

_____ I understand that recommended aftercare guidelines are crucial for healing and a reduction in the appearance of cellulite. I understand that if I gain weight during the cellulite/body contouring treatment that the results will be diminished.

ACKNOWLEDGEMENT

I understand that I release Advanced Skin Fitness and its associates, the Medical Director, the technician performing services, and any other person involved in my treatment from any liability associated with complications from the radio frequency (RF) procedure. I am aware that Advanced Skin Fitness has a 24 hour cancellation policy. Similarly, I will be charged \$100 for any broken appointment without 24 hour cancellation. I understand that after my initial package, maintenance treatments will be required at an additional charge. I understand that no guarantees can be made and all payments are non-refundable. By my signature below, I certify that I have read and fully understand the contents of this permission and authorize the performance Body Contouring/Wrinkle Reduction treatment by the staff of Advanced Skin Fitness.

Patient or legal guardian signature and date _____

Witness signature and date _____



Credit Card Charge Authorization Agreement

We request the courtesy of a 24 hour notice in the event an appointment needs to be cancelled or rescheduled. A \$75 no show fee for facial treatments and a \$100 no show fee for laser treatments will apply in the event advanced cancellation notice is not given. Appointments booked same day of service will be assessed a no show fee should cancellation become necessary. For treatments that are pre-paid, the pre-paid treatment will be forfeited without 24 hour notice of cancellation. Thank you for your cooperation.

I, _____,

hereby authorize Advanced Skin Fitness to charge my credit card used for my treatments in the amount of \$75 for a missed facial treatment or \$100 for a missed laser treatment.

I have read this entire agreement and understand that I will be held fully responsible for its terms and charges. I agree not to chargeback Advanced Skin Fitness, as long as I receive the services that are entitled to me and guidelines are followed for my rescheduling and cancellation of appointments. Twenty-four hour notice is required for all rescheduling and cancellations.

Name On Card: _____

Signature: _____

Credit Card Billing Address: _____

City, State, Zip: _____

Telephone: (____) _____

Date: ____/____/____