

Name: _____

Date of Birth: _____

Pharmacy: _____

Family Physician: _____

Dermatologist: _____

Premier Spa & Laser Center

Information Sheet

Phone: _____

Phone: _____

Last Skin Exam: _____

Past Medical History: NONE (circle if no history)

(Check all that apply)

- | | | |
|--|--|--|
| <input type="checkbox"/> Adrenal Insufficiency | <input type="checkbox"/> End Stage Renal Disease | <input type="checkbox"/> Mitral Valve Prolapse |
| <input type="checkbox"/> Anemia/Thalassemia | <input type="checkbox"/> GERD | <input type="checkbox"/> Neuromuscular Disorder |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Pacemaker |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Head Trauma | <input type="checkbox"/> Paralysis |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Hearing Loss | <input type="checkbox"/> Pneumothorax |
| <input type="checkbox"/> Atrial Fibrillation (irregular Heartbeat) | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Prostate Cancer |
| <input type="checkbox"/> Auto- Immune Disease | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Pulmonary Embolism |
| <input type="checkbox"/> Bell's Palsy | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Radiation Treatment |
| <input type="checkbox"/> Bipolar Disorder | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Renal Disorder |
| <input type="checkbox"/> Blood Clotting Disorder | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Rheumatoid Arthritis |
| <input type="checkbox"/> BPH | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Breast Cancer | <input type="checkbox"/> Hypercholesterolemia | <input type="checkbox"/> Severe Reaction to Anesthesia |
| <input type="checkbox"/> Cold Sores | <input type="checkbox"/> Hyperthyroidism | <input type="checkbox"/> Shingles |
| <input type="checkbox"/> Colon Cancer | <input type="checkbox"/> Hypothyroidism | <input type="checkbox"/> Sleep Apnea |
| <input type="checkbox"/> Congestive Heart Failure | <input type="checkbox"/> Keloids/Unusual Scarring | <input type="checkbox"/> Spinal/Back Disorder |
| <input type="checkbox"/> COPD | <input type="checkbox"/> Leukemia | <input type="checkbox"/> Stomach Problem/Ulcer |
| <input type="checkbox"/> Coronary Artery Disease | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Stroke (CVA/TIA) |
| <input type="checkbox"/> Deep Vein Thrombosis (DVT) | <input type="checkbox"/> Lung Cancer | <input type="checkbox"/> Trauma |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Lung Disease | <input type="checkbox"/> Vision Loss |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Lupus | <input type="checkbox"/> Current Cancer Treatment |
| <input type="checkbox"/> Easy Bruising | <input type="checkbox"/> Lymphoma | <input type="checkbox"/> Metallic Implants |
| | <input type="checkbox"/> Mental Health Hospitalization | <input type="checkbox"/> Other _____ |

Past Surgeries: NONE (circle if no surgical history)

(Check all that apply)

Abdomen/Abdominal Wall:

- Laparoscopy
- Laparotomy
- Hernia Repair- Left Femoral
- Hernia Repair- Left Inguinal
- Hernia Repair- Right Femoral
- Hernia Repair- Right Inguinal
- Hernia Repair- Umbilical
- Hernia Repair- Ventral
- Appendix* (Appendectomy)
- Bladder* (Cystectomy)
- Bowel Resection*

Brain:

- Surgery for Cancer
- Surgery for Trauma

Breast:

- Breast Biopsy
- Lumpectomy- Both breasts
- Lumpectomy- Left breast
- Lumpectomy- Right breast
- Mastectomy- Both breasts
- Mastectomy- Left Breast
- Mastectomy- Right Breast
- Cesarean Section*

Colon:

- Colon Cancer Resection

- Diverticulitis
- Inflammatory Bowel Disease
- Colostomy
- Esophagus-* Esophagectomy
- Gallbladder*

Heart:

- Biological Valve Replacement
- Coronary Artery Bypass Surgery
- Heart Transplant
- Mechanical Valve Replacement

Joint Replacement:

- Hip- Both
- Hip- Left
- Hip- Right
- Knee- Both
- Knee- Left
- Knee- Right

Kidney:

- Biopsy
- Stone Removal
- Transplant
- Nephrectomy

Liver:

- Hepatectomy
- Transplant
- Shunt

Lung:

- Left Upper/Lower Lobectomy
- Left Pneumonectomy
- Right Upper/Lower Lobectomy
- Right Pneumonectomy

Ovaries:

- Endometriosis
- Ovarian Cancer
- Ovarian Cyst
- Tubal Ligation
- Pancreas-* Pancreatectomy

Prostate:

- Biopsy
- Cancer
- TURP

Skin:

- Basal Cell Carcinoma
- Melanoma
- Skin Biopsy
- Squamous Cell Carcinoma
- Spine Surgery*
- Spleen-* Splenectomy

Stomach:

- Gastrectomy
- Gastostomy
- Tonsillectomy*

Uterus:

Fibroids

Uterine/Cervical Cancer

Hysterectomy

Other _____

Skin Disease:

(Check all that apply)

Acne

Actinic Keratosis

Basal Cell Carcinoma

Blistering Sunburns

Dry Skin

Eczema

Flaking or Itchy Scalp

Hay Fever/Allergies

Melanoma

Poison Ivy

Precancerous Moles

Psoriasis

Squamous Cell Skin Cancer

Other _____

Do you wear sunscreen? Yes No If Yes what SPF? _____ Do you tan in a tanning salon? Yes No

Plastic Surgery History: NONE (circle if no plastic surgery history)

(Check all that apply)

Abdomen:

Abdominal Wall Reconstruction

Abdominoplasty

Body Contouring:

Brachioplasty

Liposuction

Lower Body Lift

Thigh Lift

Upper Body Lift

Breast:

Augmentation

Lift (Mastopexy)

Reconstruction

Reduction

Implant Removal

Nipple Reconstruction

Burn Wound Reconstruction

Carpal Tunnel Release

Chemical Peel

Cleft:

Lip Repair

Palate Repair

Ears:

Reconstruction

Earlobe Repair

Otoplasty

Face:

Blepharoplasty

Brow Lift

Cheek Augmentation

Chin Augmentation

Facelift

Lefort Osteotomy

Lower Blepharoplasty

Orbital Floor Fracture

Repair of Craniosynostosis

Upper Blepharoplasty

Hair Restoration

Laser Hair Removal

Liposuction of Face

Liposuction of Neck

Nose:

Rhinoplasty

Septoplasty

Scar Revision

Other _____

Medications: Please list all medications that you are taking including topicals

| | |
|--|--|
| | |
| | |
| | |
| | |
| | |

Allergies: Please list all drug, anesthetic (numbing medication), tape, latex, iodine, or food allergy

| | |
|--|--|
| | |
| | |

Social History:

(Check all that apply)

Smoking Status: Current Former Never

Start Date: _____

Quit Date: _____

Alcohol use: None less than 1 drink per day

1-2 drinks per day 3 or more per day

Occupation: _____

Alerts: (Check all that apply)

Use of Accutane

Allergy to latex

Allergy to lidocaine

Allergy to topical antibiotic ointments

Artificial heart valve

Artificial joints within past two years

Blood thinners

History of Melanoma

Malignant hyperthermia

MRSA

Pacemaker/Defibrillator

Premedication prior to procedures

Rapid heartbeat with epinephrine

Currently Pregnant or Breastfeeding

Signature: _____ Date: _____



Beautiful skin starts here

Thank you for choosing PREMIER SPA & LASER CENTER (PSLC) for your aesthetic needs.

Please be advised that our services are elective cosmetic procedures, the care provided at Premier Spa & Laser Center is not covered by any medical insurance programs and we do not participate in any such plans. Payment is required at the time of your treatment. For specially packaged treatments, payment for the entire package is due at the time of the first scheduled treatment. The health and safety of our patients is our first priority, therefore at this time we have had to update several of our policies in the Spa, see below:

Please read and sign our financial and etiquette policy below to verify your receipt and understanding of this information.

Effective 2021

- 1. For the comfort of all our guests, please reduce or mute the volume on your cell phones, laptops, and pagers.
2. Please refrain from inappropriate language or actions. If this does occur your aesthetic provider may terminate your service, without a refund.
3. We provide a number of payment options which may be used individually or combined according to your desires. Cash, check, Visa, Mastercard and Care Credit are accepted. (Returned checks are subject to a \$30.00 service charge.)
4. We value your business and understand that sometimes schedule adjustments are necessary; therefore, we respectfully request at least 24 hours' notice for cancellations to avoid a cancellation fee.

- 5. Our appointments are confirmed 48 hours in advance because we know how easy it is to forget an appointment you booked months ago. Since the services are reserved for you personally, our cancellation/no-show policy is listed as follows:
- 1st time no show - 50% of your service will be required in order to book your next appointment
- 2nd time no show - 100% of your service will be required in order to book your next appointment

Please understand that when you forget to cancel your appointment without giving enough notice, we miss the opportunity to fill that appointment time and patients on our waiting list miss the opportunity to receive services.

- 6. Clients arriving ten minutes after their scheduled appointment time will be considered late for their appointment, and their appointment may be rescheduled as a result, allowing the provider to take their next scheduled appointment on time.
7. All consults will now require a \$50 deposit OR a credit card kept on file that will be charged in the event of a "no show" or last-minute cancellation.
8. For all Coolsculpting treatments, a deposit is required at the time of scheduling the appointment. This deposit may be forfeited, if a cancellation less than 48 hours occurs or the appointment is missed.
9. All services will now require a deposit OR a credit card kept on file that will be charged in the event of a "no show" or last-minute cancellation. The deposit will be applied once services are rendered. This deposit will be forfeited, if a cancellation less than 24 hours occurs or the appointment is missed.
10. Skin care product purchases can be returned within 30 days of purchase, ONLY if they are unopened and unused. Latisse, Renova, Retin A and Hydroquinone products cannot be returned. A refund by Premier Spa & Laser Center may not be provided in the same form of initial payment(s). All refunds will be provided by a check in the mail within 2-3 weeks of receipt of return. If you do not wish a check refund a credit can be left on your account for future service(s) and/or purchase(s) within the spa.

These policies are subject to change without notice. If you have any questions or need assistance with any financial matters relating to your treatment, please contact our Aesthetic Associates for help.

X _____ DATE: _____ MRN: _____

PATIENT, GUARANTOR, OR PERSONAL REPRESENTATIVE'S SIGNATURE

The patient/guarantor has the responsibility to inform PSLC if the patient's contact information changes, i.e. phone number, address, and email. Your signature on this page signifies that you acknowledge and accept the above policies.