MEDICAL SPA AT PRO SPORTS CLUB

NEW PATIENT INFORMATION

Today's Date: _____ Are you a member of PRO Sports Club? □ Yes □ No

PERSONAL HISTORY:

Name: _____ Prefix: □ Dr. □ Mr . □ Mrs. □ Ms. □ Miss

Preferred Name/Nickname: _____

Date of Birth: _____ Age: _____ Gender: □ Male □ Female

Marital Status: □ Single □ Married □ Divorced □ Widowed □ Other

Address: _____ □ Exclude from mailing list

City: _____ State: _____ Zip code: _____

Home Phone: _____May we use this number for appointment confirmations? □ Yes □ No

Cell Phone: _____May we use this number for appointment confirmations? □ Yes □ No

Work Phone: _____May we use this number for appointment confirmations? □ Yes □ No

E-mail Address: _____

May we contact you via email for: □ Special Events □ Scheduling □ Do not use

Occupation: _____

Please tell us how you were referred to the Medical Spa at PRO Sports club:

□ Friend □ Magazine □ Radio □ TV □ Website: _____ □ Other: _____

EMERGENCY CONTACT:

Name: _____ Contact Number: _____ Relationship: _____

PRIMARY INSURANCE:

Insurance Company: _____ ID #: _____ Group#:_____

Subscriber Name: _____Date of Birth: _____

Relationship to ensured party: _____

Please read carefully initial:

A. I (or my dependent) have insurance coverage and assign directly to PRO Sports Club all insurance benefits, if any, otherwise payable to me for services rendered. I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the PRO Sports Club practitioner to release all information necessary to secure the payment of benefits and authorize my signature below on all insurance submissions. (Initials: _____)

B. I understand that co-payments are due at the time of service. (Initials:_____)

CANCELLATION POLICY

I understand that PRO Sports Club has a 24-hour cancellation policy and that a charge will be billed to me directly if I miss any appointment or fail to provide the required 24-hour notice when cancelling an appointment. I further understand that arriving late to a scheduled appointment may result in a shortened or rescheduled appointment. (Initials: _____)

MEDICAL HISTORY

SKIN TYPE:

□ Type I: Very white or freckled - Always burns, never tans
□ Type II: White - Always burns, sometimes tans
□ Type III: White to olive - Sometimes burns, always tans
□ Type IV: Brown – Rarely burns, always tans
□ Type V: Dark brown
□ Type VI: Black

Sun Exposure:

□ I use tanning beds
□ I tan in the sun
□ I use tanning lotions and/or creams
□ I avoid sun exposure
□ I have limited sun exposure
□ I have moderate sun exposure
□ I have frequent sun exposure

Do you wear sunscreen?

□ Daily
□ Sometimes, when sunny
□ Always, when sunny
□ Rarely/Never

Please check your areas of interest:

☐ Acne Treatments
☐ Botox Treatments
☐ Cellulite Reduction
☐ Chemical Peels
☐ Dermal Fillers
☐ Laser Resurfacing
☐ Laser Hair Removal
☐ Laser Rejuvenation (Photofacial)
☐ SmartLipo (Body contouring)
☐ Skin Tightening
☐ Skin Care
☐ Spider Veins
☐ Sweat Reduction

Have you ever had any cosmetic treatments/procedures? If yes, please list what you have had and the date they were performed below:

_____

_____

Do you currently have a skincare regimen? If yes, please list the products you use below:

_____

_____

ALLERGIES and REACTIONS to Drug/Food/Latex:

_____

Current Medications and Dosage Including Topical Medications:

_____

Current Vitamins/Minerals Including Dosage:

_____

Previous Surgeries/Hospitalizations/Illnesses & Dates:

_____

Do you or any family members have problems with anesthesia? ☐ Yes ☐ No

If yes, please explain: _____

Have you ever had or have any of the following? Please check all that apply:

Personal or family History of skin cancer: ☐ Yes ☐ No Details: _____

History of pre-cancerous skin lesions or moles: ☐ Yes ☐ No Details: _____

Personal or family history of skin disease: ☐ Yes ☐ No Details: _____

☐ Arthritis
☐ Anemia
☐ Asthma
☐ Varicose Veins
☐ Clotting/Blood Disorders
☐ Migraines
☐ TMJ (teeth grinding or clenching)
☐ Fainting/Lightheadedness with needles
☐ Herpes ☐ Cold Sores ☐ Genital ☐ Shingles
☐ Seizures/Epilepsy/Convulsions
☐ Depression/Psychiatric Care/ Anxiety
☐ Sleep Apnea
☐ Easily Bruises
☐ Eczema/Atopic Dermatitis/Psoriasis
☐ Keloid Scarring
☐ Poor Wound Healing
☐ Skin Rashes
☐ Diabetes
☐ Heart disease/Heart Murmur/Stroke/Heart Attack
☐ High blood pressure
☐ Low blood pressure
☐ Hepatitis
☐ HIV/AIDS
☐ Thyroid Imbalance
☐ Hormonal Imbalance
☐ Autoimmune Disease
☐ Hyperpigmentation/Hypopigmentation
☐ Polycystic Ovarian Syndrome

Are you currently under the care of a physician or Dermatologist? ☐ Yes ☐ No
If yes, who is your physician or Dermatologist? _____
What is your preferred pharmacy? _____

For Our Female Patients:

Are you pregnant or trying to become pregnant? ☐ Yes ☐ No
Are you currently breastfeeding? ☐ Yes ☐ No
Date of last menstrual period: _____

SIGNATURE:

I certify that the information provided on this form is true and correct to the best of my knowledge.

_____

Patient Signature – Age 18 or older Date