New Guest Intake Form

Client Name: ____ **Salutation** ______

Last *First* *MI*

Street Address: ____

City, State, Zip: ____

DOB: ___________________ **Sex:** ___F ___M **Marital Status:** __S __M __D __W

Phone#: _____________ ___Cell ___Home ___Work ***Is it OK to leave a voicemail?*** ______

Alternate#: _____________ ___Cell ___Home ___Work ***Is it OK to text you?*** ______

E-Mail Address: _______________________________ ***OK to email detailed information?*** ______

What brings you in for today's appointment? ____

____

Please list any medications you are currently taking, including anything over the counter and/or herbal supplements *(you may request additional sheets from the front desk if necessary)***:**

MEDICATION NAME	DOSAGE	ROUTE	HOW OFTEN	QUANTITY

Allergies *(please provide us with the type of reaction):* ________________________________

What cosmetic treatments (i.e. lasers, Botox, fillers/injections, serums/creams) have you done previously?

____

____

Have you ever used Accutane? __**No** __**Yes – If YES, when did you stop using it?** _______________

Are you currently on an antibiotic? ____**No** ____**Yes**

HOW DID YOU HEAR ABOUT US?

- ☐ Facebook
- ☐ Instagram
- ☐ Our Website
- ☐ Friend / Family Member
  - If so, whom can we thank? ______________
- ☐ Email Newsletter
- ☐ Internet Search
- ☐ Physician Referral
  - If so, whom can we thank? ______________
- ☐ Event
  - If so, which event? ______________

Emergency Contact

Name: ____

Phone #: ____________________ **Relationship:** ____________________________

_____________________________________ _______________

Client Signature **Date**