Personal History (please print clearly)

Client's Name: _____ Today's Date: _____

Date of Birth: _____ Age: _____ Occupation: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Home Phone: _____ Work Phone: _____ Cell: _____

Best number to reach you (circle): Home Work Cell Email address: _____

Emergency Contact: _____ Contact Number: _____

How were you referred to us? _____

General History

Have you ever had laser treatments? Yes ___ No___ If so, for what and where? _____

Does your skin turn really red after a shower or a glass of wine? Yes ___ No___

Have you had any surgeries? Yes ___ No ___If so, for what? _____

Do you have any tattoos? No ____ Yes (where?)_____

Do you burn easily in the sun if you're not wearing sunscreen? Yes _____ No _____

What is your ethnicity/heritage? (please include percentages)

_____ Scandinavian
_____ Northern European (Light Caucasian)
_____ Dark Caucasian
_____ Mediterranean, Italian, Asian, or Hispanic
_____ Middle Eastern, Latin, Light African-American, Darker Hispanic, Indian, or Native American
_____ Dark African American

Are you concerned about any of the following? (Please check all that apply).

_____ Wrinkles or loose skin on face
_____ Hair in the wrong place
_____ Brown or red spots
_____ Acne on any part of my body
_____ Other: _____
_____ Dry, flaky skin or oily skin
_____ Red, blue, or purple spider veins on face, nose, or legs
_____ Unwanted tattoo(s)
_____ Scars

Medical History

Are you currently under the care of a physician or dermatologist? Yes _____No _____ If yes, for what:
_____

Do you have any of the following medical conditions? (Please circle all that apply).

Cancer Diabetes High blood pressure Herpes Arthritis Rosacea
Frequent cold sores HIV/AIDS Keloid scarring Skin disease/Skin lesions Seizure disorder
Hepatitis Hormone imbalance Thyroid imbalance PCOS Any active infections
Blood clotting abnormalities Erythema Abigne

Please list any other health problems or medical conditions you have, including internal metal devices, or pacemaker: _____

Have you ever had an allergic reaction to any of the following? *Please circle all that apply:*

Food Latex Aspirin Lidocaine Hydrocortisone Ice/Cold
Hydroquinone or skin bleaching agents Other: _____

What oral medications are you presently taking? Birth Control Hormones Other: _____

Are you on any mood altering or anti-depression medication? Yes ___ No ___ What: _____

Have you used Accutane? Yes ___ No ___ If yes, when did you last use it? _____

Do you regularly take baby aspirin, Coumadin, or other blood thinner? Yes ___No ___

What topical medications or creams are you currently using? Retin A or Other: _____

Do you take fish or flax oil supplements: Yes _____No_____ Ginkgo: Yes _____ No _____

What other dietary supplements do you take regularly? _____

Are you pregnant or trying to become? Yes ___No __Are you breast feeding? Yes ___ No ___

Are you using hormonal contraception? Yes ___No ___When is your next period? _____

I certify that the preceding medical, personal, and skin history statements are true and correct. I am aware that it is my responsibility to inform the technician, staff, or nurse of my current medical or health conditions and to update this history. I understand there are no refunds offered on unwanted treatments, and no returns are given for treatments with unsatisfactory results. I agree that if I experience negative or unexpected side effects I will first to be seen by Smooth Skin Centers before seeking advice elsewhere.

Client Signature: _____ Date:_____

Injectables Consent

I, _____ (client) authorize a staff person from Smooth Skin Centers to inject me with BOTOX© _____ and/or Juvederm™ _____. In the following form, "I" is the customer whose name appears as authorizer.

Botox©: Outline A Toxin (BOTOX) has been FDA approved for the use in cosmetic treatment for glabella frown lines only (the wrinkles between the eyebrows). Injection of BOTOX into small muscles between the brows cause those specific muscles to halt their function (be paralyzed), thereby improving the appearance of wrinkles. The goal is to decrease the wrinkles in the treated area. The paralysis is temporary, and re-injection is typically necessary within two to four months.

Juvederm™: Juvederm injectable gel is a colorless hyaluronic acid gel that is injected into facial tissue to smooth wrinkles and folds, especially around the nose and mouth. Hyaluronic acid is a naturally occurring sugar found in the human body. The role of hyaluronic acid in the skin is to deliver nutrients, hydrate the skin by holding in water, and to act as a cushioning agent. Juvederm injectable gel is injected into areas of facial tissue where moderate to severe facial wrinkles and folds occur. Juvederm injectable gel temporarily adds volume to the skin and may give the appearance of a smoother surface. Most customers need one treatment to achieve optimal wrinkle smoothing, and the results last about nine months to one year.

I agree to all that I initial:

___ I consent to the taking of photographs during the course of my injections therapy for healthcare records.
___ I consent to using my photographs for medical education and/or marketing purposes. My full name will not be used to identify these photographs.
___ I have provided my past and current medical history and medications and understand it is my responsibility to keep Smooth Skin Centers aware of any changes to my medical history and medication usage.
___ I will not have a chemical peel, facial, microdermabrasion, laser treatment or other aesthetics treatment for a period of one week before or after my BOTOX or six weeks before or after my Juvederm injections without the express, written consent of my injector.
___ If I have a history of severe allergies marked by a history of anaphylaxis or history or presence of multiple severe allergies, including a history of allergies to Gram-positive bacterial proteins, I have alerted my injector to this fact.
___ I am not pregnant (female patients)
___ I have received the after-care instructions provided by Smooth Skin Centers.
___ I understand that it is my responsibility to follow the after care instructions given to me by the Smooth Skin Centers staff (both orally and in written form), and that my failure to adhere to these recommendations may result in complications and contraindications for which I am fully responsible.
___ The performances of this procedure(s) have been discussed with me, and I understand that my skin's condition may actually temporarily worsen as a result of this treatment.

___ I understand that for up to eight weeks or longer following the injection treatment, temporary side effects may occur, including but not limited to: redness, swelling, blistering, itching, discomfort, bruising and discoloration (hyper- and hypo-pigmentation), back ache, flu-like symptoms including fever, drooping skin including droopy eyelid, and that scarring, while rare, is also possible.

___I understand that any discoloration may last fourteen days or longer and swelling should resolve within several days, but may last longer. Discomfort may be treated with the application of cool compress or topical soothing agents, as well as protocols suggested by Smooth Skin Centers.

___ I understand that because my body is a living entity, prior experiences and results with Botox and Juvederm are in no way indicative of the outcome of current and future treatments, and that more or less product may be necessary in different injection sites to achieve satisfactory results.

___ I recognize that Injectables, including Botox and Juvederm, are biological procedures and the act of injecting these products is not an exact science, and I acknowledge that no guarantees have been made to me concerning the results of such procedures and thus no monetary refunds will be issued to me if I am unhappy with the results which may vary than what I expect.

___ By signing this form, I understand that complete satisfaction may not be possible, and that multiple treatments may be needed for the best results.

___ I understand I must give at least a 48-hour cancellation or re-scheduling notice, and that if I am running more than 10 minutes late for a treatment that there may not be enough time to get my injectables, but I will be responsible for paying for the procedure. I understand that if I miss an appointment I will be responsible for paying for the procedure.

___ I understand that Smooth Skin Centers, Inc. may need to reschedule my appointment without notice, due to circumstances beyond its control, and this is not grounds for a refund.

___ I have received, read and understand the after-care instructions provided for by Smooth Skin Centers, Inc.

___ I have been given the opportunity to ask questions about the procedure(s). My questions have been answered, and I understand the information given to me.

____ I have read and understood all information presented to me before signing this consent form and hereby releases the injector, as well as Smooth Skin Centers, Inc., its employees, staff, and medical director from all liabilities associated with the above indicated procedures.

___ I agree that if I experience alarm or concern regarding my treatment that I need to immediately both notify and be physically seen by Smooth Skin Centers prior to being seen by any other health care provider in order to get direction and feedback and that if I chose to seek advice elsewhere or self-treat any side effects prior to being seen by Smooth Skin Centers I am 100% responsible for any effect or contraindication that may or may not occur.

Client Signature: _____ Date: _____

Injector: _____ Date:_____

Acknowledgment of Missed Appointment Policy

We're happy to have you as a client. Really! And we do everything we can to help you achieve the results you want. To help you stay on schedule, we will send out automated text and email reminders TWO days before your appointment. If you need to cancel or reschedule your LASER appointment, please do so by noon the day before your scheduled appointment. If you have to cancel your BOTOX or JUVEDERM appointment, please do so by 3:00 pm TWO DAYS prior to your scheduled appointment. This gives us a chance to rebook the time we had reserved for you. Should you cancel your appointment past this cut-off time, you will be assessed a reschedule charge of at least $35 per treatment or per 15-minute block.

If you cancel your appointment the same day you are scheduled, you will be expected to pay for all the treatments you are scheduled for. Once you've arrived for your appointment, you will be expected to pay for all the treatments you are scheduled for, even if you decide not to do the treatments or have sun exposure or have had other services that could cause negative side effects in conjunction with our service. If you are late to your appointment and we don't have enough time to do what you had scheduled, you will be expected to pay for all the treatments you are schedule for, even if we don't have time to do the treatments.

Authorization: *By signing below, I authorize Smooth Skin Centers to charge my credit card for the cancellation fees explained in the above paragraphs. I understand I will not receive further treatments if I have an unpaid balance as a result of not providing a credit card number or if Smooth Skin Centers is unable to process a missed appointment charge.*

Today's Date _____

Your Name (please print) _____

Client Signature: _____

Email address: _____

Card Number: __ __ __ __ - __ __ __ __ - __ __ __ __ - __ __ __ __

Expiration date _ _ / _ _ _ _ Code on back __ __ __ Zip Code __ __ __ __ __

This information is kept strictly confidential.

If you do not want to provide your credit card number, we ask that you please read and sign this form and return it to us. Your signature acknowledges you are aware of and agree with and give permission to these described policies. Thanks!