



Ageless in the Triad

Facial/Injections/Skincare

Thank you for choosing Ageless in the Triad for your anti-aging and cosmetic needs. Please answer the following questions so that we may better understand your health and lifestyle.

Name _____ Phone _____ Date of Birth _____

Address _____

City _____ State _____ Zip Code _____

Emergency Contact/Relationship _____ Phone _____

Email _____ Occupation _____

Referred by _____ How did you hear about us? _____

Health History (Mark all that apply)

- | | | | |
|---|---|--|---|
| <input type="checkbox"/> Thyroid Disorders | <input type="checkbox"/> Digestive Issues | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Anxiety |
| <input type="checkbox"/> Numbness/Tingling | <input type="checkbox"/> Lymph Edema | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Hernia |
| <input type="checkbox"/> Rashes | <input type="checkbox"/> Sinus Problems | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Varicose Veins | <input type="checkbox"/> Allergies | <input type="checkbox"/> Chronic Pain |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Jaw Pain/TMJ | <input type="checkbox"/> Low Blood Pressure |
| <input type="checkbox"/> Broken Bones | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Gas/Bloating | <input type="checkbox"/> Sprains/Strains |
| <input type="checkbox"/> Back Pain | <input type="checkbox"/> Depression | <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart Condition |
| <input type="checkbox"/> Spasms/Cramps | <input type="checkbox"/> Herpes/Cold Sore | <input type="checkbox"/> Pregnancy | <input type="checkbox"/> Blood Clots |
| <input type="checkbox"/> Muscular dystrophy | <input type="checkbox"/> Seizures | | |

How is your general health? Excellent Good Fair Poor

Do you smoke? _____

Medications: Please list all oral and topical medications that you are currently taking; include dosage and frequency. Please also include any over the counter supplements

Past Surgical History: (List Previous Surgeries) _____

Do you have any known allergies? _____

Do you wear glasses or contact lenses? _____

Skincare History

Which of the following best describes your skin type?

- Very oily skin, large pores Oily skin Combination skin, oily in t-zone, dry to normal cheeks
 Normal Skin Dry skin Sensitive Skin

Skin Care/What is your daily skin care routine?

Have you experienced or presently experiencing? Acne Broken Capillaries Dermatitis Treatment Reactions
 Hyper or Hypopigmentation Keloid Scarring Rosacea

Have you ever been prescribed or used the following products? Tretinoin (Retin A, Retin-A Micro®, Renova, Avita) Adepalene (Differin®) Azelacic Acid (Azelex®, Finacea™) Tazarotene (Tazorac®) Triluma
 Isotretinoin (Accutane for acne) Metrogel Other _____

Do you have a tendency to scar? _____

Have you ever been diagnosed with skin cancer? _____

Sun History & Lifestyle

Do you use sunscreen? _____

What level of protection? _____

Do you sunbathe or participate in outdoor activities? _____

Do you use self tanners? _____

Do you tan in a tanning booth? _____

Have you tanned in a tanning booth or had any unprotected sun exposure in the last 7 to 10 days? _____

When exposed to the sun, do you? Always Burn, Never Tan Sometimes Burn, Sometimes Tan
 Always Tan, Never Burn

Previous Procedures:

Botox/Dysport/Xeomin

Fillers (Juvederm/Restalyne/Voluma/Radiesse)

Kybella

Chemical Peels

Facials

Electrolysis

Waxing/Threading

Tattoo Removal

Laser Hair Removal

Permanent Make-up

Skin Resurfacing

Skin Rejuvenation (IPL)

Body Contouring

Facial Cosmetic Surgery

Have you ever had an adverse reaction to laser or other cosmetic treatments? _____

What skin conditions do you want to improve? Acne and/or Breakouts Dehydration Enlarged Pores
 Excess Oil Fine Lines and Wrinkles Facial Scarring Hyperpigmentation (freckles, age spots) Hypopigmentation
 Rosacea Skin Laxity Sun Damage Uneven Tone/Texture

What bothers you the most about your skin and/or facial features? _____

Is there any other necessary information we need to know before beginning your treatment? If so, please explain:

I have acknowledged that all the information provided by me is true and correct to the best of my knowledge. I also understand that some skin conditions may require more than one treatment and home care products to achieve the results desired. I hereby release Ageless in the Triad from any liability pertaining to treatments, understanding that results cannot be guaranteed due to individual skin type(s) and condition(s)

Cancellation Policy

As a courtesy to our spa professionals, please provide a minimum of 24 hours' notice should you need to cancel or reschedule an appointment. There will be a charge of 50% of scheduled services for cancellations of less than 24 hours' notice. If you have a series, one service from this series will be deducted. For filler appointments, a \$100 deposit will be taken when scheduling the appointment and will be applied toward the filler service. However, if you fail to show for your appointment, we hold the right to keep the deposit. By scheduling an appointment, you are agreeing to our cancellation policy. Cancellations for Monday appointments are required to be cancelled by Friday at 4PM. When booking an appointment, a credit card will be needed to hold the appointment. We take Visa, MasterCard, Discover, American Express and Care Credit. We thank you for your understanding.

Late Policy

Your appointment time is reserved exclusively for you! If your arrival time is 15 minutes or later than your scheduled appointment, this may result in a shortened appointment. We reserve the right to reschedule your appointment.

No Show Policy

There will be a charge of 50% of scheduled services. If you have a series; one service from this series will be deducted. If you have a gift card, the amount will be deducted from the gift card.

For Botox/Dysport patients, a \$50 fee will be charged to your credit card for missed appointments or reoccurring late cancellations.

Payments/Refunds

Payments for all procedures at Ageless in the Triad are due at the time of service and are non-refundable. All sales are final. However, Ageless in the Triad does have an exchange policy that gives you options if the need arises. Should you wish to discontinue your treatments in the midst of a series, you will receive pro-rated credit for the unused treatments. The treatments that have already been provided will be charged at current single treatment prices to calculate the remaining credit. This credit may be used to purchase other treatments, not products, offered at Ageless in the Triad.

Client Signature _____ Date _____

Reviewed By _____ Date _____



Patient Communication Directive with Individuals Involved in Your Care

ORIGINAL WILL BE SCANNED INTO YOUR MEDICAL RECORD

PATIENT IDENTIFICATION

NAME: _____

DATE OF BIRTH: _____

Please list all individuals who may be involved in coordinating your care, payment of your care, or to whom we may provide the details of your care.

Name

Relationship to Patient

NOTE: We will continue to rely on the information on this form when communicating with family members or others involved in your care unless you request changes. Please promptly notify us if you wish to alter the designations above.

Signature of Patient/
Legal Representative: _____

Date: _____

Relationship to Patient: _____

To revoke this authorization, please send a written request to:

Ageless in the Triad Med spa
900 Old Winston Road, Suite 204B
Kernersville, NC 27284