Ageless in the Triad

Facial/Skincare Intake

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_____Age_____

City_____State_____Zip Code _____

Emergency Contact/Relationship_____Phone_____

Email_____Occupation_____

Referred by_____How did you hear about us?_____

Health History
(Mark all that apply)

___Thyroid Disorders
___Numbness/Tingling
___Rashes
___Constipation
___Headaches
___Broken Bones
___Back Pain
___Spasms/Cramps
___ Muscular Dystrophy

___Digestive Issues
___Lymph Edema
___Sinus Problems
___Varicose Veins
___Diabetes
___Arthritis
___Depression
___Herpes/Cold Sore
___ Seizures

___HIV/AIDS
___Hepatitis
___High Blood Pressure
___Allergies
___Jaw Pain/TMJ
___Gas/Bloating
___Cancer
___Breastfeeding
___ Pregnancy

___Anxiety
___Hernia
___Asthma
___Chronic Pain
___Low Blood Pressure
___Sprains/Strains
___Heart Condition
___Blood Clots

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

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.

Patient Rights:

- I have the right to revoke this authorization at any time by contacting this office.
- I may inspect or copy the protected health information to be disclosed as described in this document.
- Revocation is not effective in cases where the information has already been disclosed but will be effective going forward.
- Information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.
- I have the right to refuse to sign this authorization and know that my treatment will not be conditioned on signing.

Signature of Patient/
Legal Representative: _____ Date: _____

Relationship to Patient: _____

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

Practice Manager
Ageless in the Triad, PC
900 Old Winston Road, Suite 204B
Kernersville, NC 27284