To help us serve you, please take a moment to complete this information.

Name _____ Date_____

Email _____

Address _____

City _____ State _____ Zip _____

Home # _____ Cell # _____ Is texting ok_____

Primary Care Provider Name and phone: _____

Date of Birth _____ Female _____ Male _____

List of Medications and Supplements

Please list all of your current medications, including over the counter vitamins and supplements

1) _____

2) _____

3) _____

Please list allergies to medications and over the counter products. □ No known allergies

1) _____
2) _____
3) _____

Hospitalizations/Surgeries including plastic surgery or other face/neck surgery

_____

_____

Please list any abnormal skin conditions _____

If in the care of a dermatologist and for what?

_____

Are you pregnant? _____ Trying to get pregnant? _____ Nursing? _____

Ethnic Origin: Caucasian _____ African American _____ Asian _____ Hispanic _____ Middle Eastern _____

Native American _____ Other _____

Do you use tobacco? _____ Drug use? _____ Excessive Alcohol? _____

Patient Signature _____

Bel Esprit Medical Spa Provider Signature _____ PH: 970-221-1280