Intake Form

Last Name: _____ First Name: _____
Date:_____

_____

_____

Address, City, State, Zip

Phone Numbers:

Home: _____ Work: _____ Cell:_____

D.O.B.: _____ Age_____
Email:_____

Do you give us permission to contact you via email? (i.e. confirmations, follow ups & promotions?) Y / N

**Do you give us permission to send mail to your residence? Y / N

Emergency Contact Name & Number:

_____

Where did you find out about us: Google □ Instagram □ Facebook □ Advertisement □ Other □
Friend/Family □ (Name?:_____)

Occupation: _____ Ethnicity/Race:_____

List ALL medications, supplements, or herbal/homeopathic remedies you currently take:

_____

_____

_____

List ALL Allergies:

_____

Have you ever had an adverse reaction to a cosmetic product? Y / N If yes, please explain:

_____

If you've used any of the above have you used them within the last 3 months? Y / N

Do you wear (Please Circle Y or N): Contacts/Glasses: Y / N Hearing Aid: Y / N Dentures: Y / N

Please indicate if you've had or used the following:

□ Laser Treatments □ Depilatories □ Chemical Peels □ Differin/Adapalene gel □ Tanning Beds
□ Electrolysis □ Microdermabrasion □ AHA/Glycolic Acid □ Waxing/Tweezing □ Cosmetic Surgery
□ Retin-A/Tretinoin □ BHA/Salicylic Acid □ Facial □ Botox/Filler □ Accutane: When:_____

Lifestyle: Please Circle

Smoking Y / N Amnt (per week): _____ Caffeine Y / N Amnt (per day): _____

Alcohol Y / N Amnt (per month: _____ Exercise Y / N Amnt (per week): _____

Surgery: Please list any previous surgeries and their dates (including cosmetic surgery):

_____

_____

Medical History: Please Circle Y or N whether you have or have ever had the following:

Abnormal Bleeding Y / N	Asthma/Difficulty Breathing Y / N	Kidney/Liver Disease Y / N
Abnormal Clotting Y / N	Diabetes Y / N	Auto Immune Disorder Y / N
Herpes Y / N	Dizziness/fainting Y / N	Arrhythmias Y / N
Skin Cancer Y / N	Acne Y / N	Pace Maker Y / N
Cancer Y / N	Heart Attack Y / N	Hormone Imbalance Y / N
Keloid Scarring Y / N	High Blood Pressure Y / N	Difficulty Breathing Y / N
Epilepsy (seizures) Y / N	Thyroid problems Y / N	Psychological Illness Y / N
Skin disease/lesions Y / N	Tuberculosis Y / N	HIV/AIDS Y / N
Frequent Cold Sores Y / N	Pigment changes after skin injury Y / N	Hepatitis Y / N
Eating Disorder Y / N	Poor wound healing Y / N	Hernia Y / N

*Please explain reasons for circling yes to any of the above or please explain other conditions you have that are not listed above:

_____

_____

For **Female** clients only:

Are you taking any oral contraceptives? Y / N

Are pregnant or trying to become pregnant? Y / N

Are you lactating? Y / N

Are you experiencing any menopausal problems? Y/N
Specify:_____ _____

I certify that the above information is correct to the best of my knowledge. In accordance with the law, Dr. Moran Medical Aesthetics, LLC cannot cure, treat, prevent, or diagnose any condition. These treatments are used as regimens for improving skin appearance and wellness. Information exchanged during any session should be given at my own discretion. Because certain esthetic treatments should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions and answered all questions honestly. I agree to keep Dr. Moran updated as to any changes in my health prior to any future sessions and understand that there shall be no liability on the specialist's part nor on the part of Dr. Moran Medical Aesthetics, LLC. Should I fail to do so Dr. Moran reserves the right to refuse service to anyone for any reason. I fully understand that the Dr. Moran performs her services within the parameters of esthetics, using skin care treatments and therapies . If I experience any pain or discomfort during the session, I will immediately inform Dr. Moran so that the products and/or techniques may be adjusted to my level of comfort. By signing below, I acknowledge that I have read and understand all parts of this consent/intake form, and that I have had the opportunity to ask any questions with regard to any services offered. All client information is confidential.

Signature: _____ Date: _____

If under 18: Relationship: (circle) Patient Spouse Parent Guardian

Signature:_____

Photo Policy: As a part of your care at Dr. Moran Medical Aesthetics LLC, we take photographs for assorted reasons in order to serve you better. Photographs are taken for identifying purposes as well as for tracking your treatment results.

1.) I consent to a photograph being taken for identifying purposes to be used at Dr. Moran Medical Aesthetics LLC. I understand this photo will be used for internal purposes ONLY.
YES Initials:_____ **NO Initials**:_____

2.) I consent to photographs being used for **internal** marketing (i.e. In-office before/after books) knowing that Dr. Moran will do her best to remove any identifying marks (black bar over eyes or tattoos, removal of jewelry, etc.).
YES Initials:_____ **NO Initials**:_____

3.) I consent to my photographs being used for **external** marketing (i.e. Website, Facebook, Instagram, etc.) knowing that Dr. Moran will do her best to remove any identifying marks (black bar over eyes or tattoos, removal of jewelry, etc.).
YES Initials:_____ **NO Initials**:_____

Refund Policy: Dr. Moran Medical Aesthetics is committed to providing excellent service along with individually customized treatments. Though we do our best to achieve your desired, realistic outcome, we do NOT issue a refund or credit after treatments are purchased or rendered. All quotes are valid for 30 days, unless otherwise specified from time of consultation. Some procedures performed at Dr. Moran Medical Aesthetics LLC may require a non-refundable deposit to book. Any balance remaining will be due at the time of the first appointment. Any procedures cancelled once the deposit is given will not be refunded back, but may be used, at the discretion of Dr. Moran Medical Aesthetics LLC, as a facility credit towards another procedure. All facility credits must be used within 3 months from the date of purchase, unless otherwise specified. Any deposits not used within 3 months of payment are forfeited

By signing below, I acknowledge I have read over and understand Dr. Moran Medical Aesthetics LLC practice policies. I have had the opportunity to ask any questions regarding any policy provided by Dr. Moran Medical Aesthetics LLC.

Signature: _____ Date: _____

Cosmetic Interest Questionnaire

Our mission is to provide you with a variety of treatments to fit your needs and to educate you about what services we offer. Please take a moment to fill out the below survey so we may find out what we can do to serve you better!

Patient Name:_____

Reason for visit?:_____ Date:_____

Have you ever received professional skin care/esthetic treatments? Yes / No
If yes, what
type:_____
_____
_____ _____
What is your current skin care regimen? What products are you using?
_____ _____
_____
_____

How would you rate the overall quality of your skin? (Circle One)
POOR FAIR GOOD VERY GOOD EXCELLENT
What improvements would you like to see to your skin?
_____
_____
What services or concerns would you like to learn about? Please check all that apply.

☐ How to care for my skin	☐ Skin Rejuvenation	☐ Injectable Treatments
☐ Fillers	☐ Facial fine lines/wrinkles	☐ Thin lips
☐ Blotchy skin	☐ Chemical Peel	☐ Brown spots/age spots/freckle
☐ Drooping brow	☐ Drooping eyelids	☐ Facial fullness/drooping
☐ Neck Wrinkles	☐ Length/Fullness of Eyelashes	☐ Double Chin
☐ Facial Contouring		

Please answer the following questions on a scale of 1 to 5 by circling the appropriate number.
When looking at my face in the mirror, I believe I look younger, the same as, or older than my true age.

Younger Than		**True Age**		**Older Than**
1	2	3	4	5

When looking in the mirror, I am not concerned, somewhat concerned, or very concerned about the appearance of my wrinkles.

Not Concerned		**Somewhat Concerned**		**Very Concerned**
1	2	3	4	5