



*Esthetician Services*

Please fill out all information as completely as possible. This information will help us in processing your office visit and make your visit a smoother, quicker and more efficient process. Please have all insurance cards and information needed at the time of your visit.  
Thank you!

**PATIENT INFORMATION**

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
 Address: \_\_\_\_\_ Sex: \_\_\_\_\_ Age: \_\_\_\_\_ Marital Status: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Social Security #: \_\_\_\_\_  
 Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_  
 Employer Name: \_\_\_\_\_ Occupation: \_\_\_\_\_  
 Spouse Name: \_\_\_\_\_ Social Security #: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

**ADDITIONAL INFORMATION**

What is the chief complaint that brought you to the office:  
 \_\_\_\_\_  
 Pharmacy Name: \_\_\_\_\_ Pharmacy Location: \_\_\_\_\_  
 Referring Source: \_\_\_\_\_  
 Your e-mail address: \_\_\_\_\_  
 Receive our cosmetic newsletters'/e-mail's? Y N (CIRCLE ONE)  
 Are you currently using skincare? Y N (CIRCLE ONE)  
 If so, what line: \_\_\_\_\_  
 Are you currently using Latisse? Y N (CIRCLE ONE)  
 If not, are you interested? Y N (CIRCLE ONE)

**EMERGENCY CONTACT**

Person to notify (in case of emergency): \_\_\_\_\_  
 Relationship: \_\_\_\_\_  
 Phone #: \_\_\_\_\_

The above information is true to the best of my knowledge.  
 I understand that I am financially responsible for any balance due at the time of service.

\_\_\_\_\_ Patient Name

\_\_\_\_\_ Date



**PLEASE ANSWER ALL OF THE FOLLOWING:**

**YOUR HEALTH:**

- |  | <b>Yes</b>               | <b>No</b>                |
|--|--------------------------|--------------------------|
| Within the last year, have you been under a dermatologist's or other physician's care? | <input type="checkbox"/> | <input type="checkbox"/> |
| Within the last nine months, have you undergone any surgery?                           | <input type="checkbox"/> | <input type="checkbox"/> |
| If yes, please specify: _____  |                          |                          |
| Do you wear contact lenses?  | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you have metal implants, a pacemaker or body piercings?                             | <input type="checkbox"/> | <input type="checkbox"/> |

List any medications, supplements, vitamins, diuretics, slimming tablets ect. That you take regularly:

\_\_\_\_\_

\_\_\_\_\_

**YOUR SKIN:**

- |  | <b>Yes</b>               | <b>No</b>                |
|--|--------------------------|--------------------------|
| Do you use Accutane, Retin-A, Renova, Adapalene or any other prescription skin products? | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever had chemical peels, Microdermabrasion or any resurfacing treatments?       | <input type="checkbox"/> | <input type="checkbox"/> |

What skincare products are you currently using? \_\_\_\_\_

\_\_\_\_\_

Are you currently using any products that contain the following ingredients:

- glycolic acid    lactic acid    hydroxy acid    vitamin A derivatives (ie., retinol)    exfoliating scrubs

Do you ever experience these conditions with your skin:

- flakiness    tightness    obvious dryness    oily    breakouts

**CAPILLARY ACTIVITY:**

- |  | <b>Yes</b>               | <b>No</b>                |
|--|--------------------------|--------------------------|
| Do you sunbathe or use tanning beds?     | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you burn easily in moderate sunlight? | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you have a tendency to redness?       | <input type="checkbox"/> | <input type="checkbox"/> |

What SPF sunscreen do you use on your face? \_\_\_\_\_ Body? \_\_\_\_\_

**NERVE ACTIVITY:**

- |   | <b>Yes</b>               | <b>No</b>                |
|---|--------------------------|--------------------------|
| Do you ever experience a burning, itching sensation on your skin?   | <input type="checkbox"/> | <input type="checkbox"/> |
| What is your pain threshold? <input type="checkbox"/> <b>Low</b> <input type="checkbox"/> <b>Medium</b> <input type="checkbox"/> <b>High</b>  |                          |                          |
| What type of massage pressure do you prefer? <input type="checkbox"/> <b>Light</b> <input type="checkbox"/> <b>Medium</b> <input type="checkbox"/> <b>Firm</b>  |                          |                          |
| Have you had a reaction to any of the following:  |                          |                          |
| <input type="checkbox"/> cosmetics <input type="checkbox"/> medicine <input type="checkbox"/> iodine <input type="checkbox"/> pollen <input type="checkbox"/> food <input type="checkbox"/> hydroxy acids <input type="checkbox"/> animals <input type="checkbox"/> fragrance |                          |                          |
| <input type="checkbox"/> sunscreens <input type="checkbox"/> other: _____   |                          |                          |

**FEMALE CLIENTS ONLY:**

- |  | <b>Yes</b>               | <b>No</b>                |
|--|--------------------------|--------------------------|
| Are you pregnant or trying to become pregnant? | <input type="checkbox"/> | <input type="checkbox"/> |

**QUESTIONS TO DISCUSS EVERY VISIT:**

- |  | <b>Yes</b>               | <b>No</b>                |
|--|--------------------------|--------------------------|
| Are you currently having or due to have your menstrual period? | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you started any new medications since your last visit?    | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you had any recent dental x-rays?                         | <input type="checkbox"/> | <input type="checkbox"/> |

What are your skin care goals? \_\_\_\_\_

**I confirm, to the best of my knowledge, that the answers I have given are correct and that I have not withheld any information that may be relevant to my treatment.**

\_\_\_\_\_  
**Patient Name**

\_\_\_\_\_  
**Date**



*Randy Tate, M.D.*  
CENTRE FOR FACIAL PLASTIC SURGERY

## **ACKNOWLEDGMENTS**

- ***I AGREE TO THE FINANCIAL POLICY FOR DR. RANDY TATE OF THE CENTRE OF FACIAL PLASTIC SURGERY.***
  
- ***I ACKNOWLEDGE THAT I HAVE RECEIVED A COPY OF THE “NOTICE OF PRIVACY PRACTICES” (HIPPA) FROM DR. RANDY TATE’S OFFICE***
  
- ***I UNDERSTAND DR. RANDY TATE IS LICENSED BY THE MEDICAL BOARD OF CALIFORNIA.***

***Patient Signature:*** \_\_\_\_\_

***Date:*** \_\_\_\_\_