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# **Medical Spa PICO Intake Form**

# **Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Last Name First Name MI

**Address:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Phone**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Street City, State, Zip

**Email:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Ethnic Background: Gender: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Emergency Contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**How did you hear about us?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**What is the main reason for your visit today? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

GOALS

YES | NO Do you want to fade your tattoo?

YES | NO Do you want to remove your tattoo?

YES | NO Are you working with a tattoo artist?

If YES, where: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If YES, who: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

YES | NO Do you understand how laser tattoo

 removal works?

MEDICAL HISTORY

(“X” all that apply)

\_\_\_\_\_ Migraines Epilepsy/Seizures \_\_\_\_\_ \_\_\_\_\_ Fainting Communicable Disease \_\_\_\_\_

\_\_\_\_\_ Diabetes History of Accutane or Retin A \_\_\_\_\_

\_\_\_\_\_ Use of Blood Metal Implants/Piercings \_\_\_\_\_

\_\_\_\_\_ Heart Issues Thinners/Aspirin/NSAIDS \_\_\_\_\_ \_\_\_\_\_ Pacemaker

**PERSONAL HEALTH HISTORY**

**Do you use a tanning bed or self-tanners? If yes, how often? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Do you smoke? If yes, how often?**

**Do you exercise? If yes, how often?**

**How many glasses of water do you consume per day?**

**Are you pregnant or nursing? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Please read and initial below:** (please initial all) The information on this form is correct to the best of my knowledge.

 (please initial) I have read the HIPAA Acknowledgement Form & Notice of Privacy Practice.

 (please initial) I understand that cosmetic treatment results vary & are not guaranteed.

 (please initial) I understand that refunds are not issued for cosmetic services performed. Refunds on retail product must be returned within 30 days of purchase for an exchange or Med Spa credit only.

 (please initial) I am aware that Twin Ports Dermatology requires a 24 - hour notice for cancellations or rescheduling. Failure to do so will result in a $50 “no show” fee..

**Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 