

BAIR MEDICAL SPA

*Facial Enhancement | Skin Rejuvenation
Body Contouring | Hair Reduction | Anti-aging*

CLIENT INFORMATION:

Name _____ Date of Birth _____

Home Phone _____ Work Phone _____

Mobile Phone _____ E-mail Address _____

Mailing Address _____

City _____ State _____ ZIP Code _____

May we contact you? Yes No

If yes, preferred contact methods?

Home Phone Work Phone Mobile Phone E-mail Mail

In case of emergency, please contact:

Name _____ Phone Number _____

Relationship _____ Alternate Phone Number _____

How did you hear about us?

Internet:

American Health & Beauty™

GETPROLO.com

Another Client:

Whom may we thank? _____

Albuquerque the Magazine

Dex™ Official Directory

Drove-by/Walked-in

Another Physican:

Whom may we thank? _____

Other _____

Have you visited our website?

Yes No

To better suit your needs, when is the best day and time for an appointment?

Monday Tuesday Wednesday Thursday Friday Saturday

9 am - 10 am 10 am - 12 noon 12 noon - 2 pm 2 pm - 4 pm 4 pm - 5 pm 5 pm - 6 pm

HEALTH HISTORY:

Are you currently under the care of a physician?

Yes No

If yes, for what conditions are you being treated? _____

Do you currently have any significant illnesses or have you had any significant illnesses in the past?

Yes No

If yes, please list: _____

Have you ever had surgery?

Yes No

If yes, please list: _____

Have you ever had any cosmetic procedures?

Yes No

If yes, please list: _____

Do you take any medications regularly?

Yes No

If yes, please list (Please also list over-the-counter medications): _____

Do you have any allergies or do you react to any medications?

Yes No

If yes, please list: _____

Do you currently have, or have you had in the past, illnesses of:

- | | | |
|---|--|---|
| <input type="checkbox"/> Skin | <input type="checkbox"/> Brain or Nervous System | <input type="checkbox"/> Bladder or Kidneys |
| <input type="checkbox"/> Heart or Lungs | <input type="checkbox"/> Digestive System | <input type="checkbox"/> Muscles, Bones or Joints |
| <input type="checkbox"/> Eyes, Ears, Nose or Throat | <input type="checkbox"/> Liver | <input type="checkbox"/> Thyroid or Diabetes |

PHOTOGRAPHY RELEASE:

I authorize Bair Medical Spa to take photographs of me and use them as an aid in my treatment. I understand that these photographs will help document the progress of my treatment. I hereby authorize and consent to the above-described photography.

Client's Signature _____ Date _____

These photographs will be completely confidential unless signed below.

I hereby authorize and consent to the above-described photography being used by Bair Medical Spa for study reporting or promotional purposes and that any photographs taken will remain the property of Bair Medical Spa. If used for any of these purposes, I understand that my identity will be kept strictly confidential— no names will be released.

Client's Signature _____ Date _____