RejuvenationMD®
Aesthetic Skin Treatment & Wellness Center

NEW PATIENT INFORMATION

PATIENT DEMOGRAPHICS

Name: _____ Birthday: _____ /_____ /_____

Preferred Pronouns: _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Phone: ( ) _____ - _____ Email Address: _____

Occupation: _____ Employer: _____

Emergency Contact: _____ Phone: ( ) _____ - _____ Relationship: _____

How were you referred to us? _____

TODAY'S CONCERNS

What is your top concern for today's 30-minute consultation visit? _____

Is there a budget you have in mind? _____

Are there upcoming events you are preparing for and when? _____

MEDICAL HISTORY

Do you smoke? ☐ Yes ☐ No If yes, check all that apply: ☐ Tobacco ☐ Marijuana ☐ Vape

Do you drink alcohol? ☐ Yes ☐ No

Do you have any of the following medical conditions? (Check all that apply)

☐ **Cancer**	☐ **Diabetes**	☐ **Metal Implants (incl IUDs)**	☐ **High blood pressure**
☐ **Cold Sores**	☐ **Genital Herpes**	☐ **Migraines**	☐ **Seizure Disorder**
☐ **Hepatitis**	☐ **Hormone Imbalance**	☐ **Sexual Dysfunction**	☐ **Urine Incontinence**
☐ **Seizure Disorder**	☐ **Clotting Issues**	☐ **Autoimmune Disease**	☐ **HIV/AIDS**

Please list any other health conditions: _____

For females: Are you pregnant? ☐ Yes ☐ No Are you breastfeeding? ☐ Yes ☐ No

Have you ever had any noninvasive or surgical aesthetic procedures? ☐ No ☐ Yes

If yes, please list: _____

MEDICATIONS

Please list any **oral** medications that you are taking: _____

Have you ever used Accutane? ☐ Yes ☐ No If yes, when did you last use it? _____

Do you have any known ALLERGIES: ☐ Yes ☐ No If yes, please list: _____

ACKNOWLEDGEMENT

I certify that the preceding medical, personal, and skin history statements are true and correct. I am aware that it is my responsibility to inform the doctor, esthetician, or staff of my current medical conditions/medications and to update this history. I understand that any products or procedures not utilized within 12 months of purchase date will be forfeited. I also have been made aware that there are no refunds for deposits, payments or treatments received, 2 days' notice is required for cancellations, or a fee may be incurred or scheduled procedure forfeited, and children & pets are not recommended and/or allowed to be in the office.

Signature: _____ **Date:** _____

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NEW PATIENT POLICIES AND AUTHORIZATIONS

OFFICE POLICIES

• No refunds. All sales, including deposits, are final. Store credit may be authorized in lieu of a refund for unused services or unopened products.
• Forfeiture. Treatments, deposits, or credit not used within 12 months of purchase are forfeited.
• Cancellations. We require 2 business days' notice to cancel or reschedule. Late cancellations/no-shows may incur a minimum of a $100 fee and/or forfeiture of deposit and/or the scheduled but missed treatment itself. Arrivals more than 15 minutes late may need to be rescheduled.
• Children. Minors are welcome for treatment with a parent present or signed consent; we ask that children not accompany you otherwise, as childcare is not available on site.
• Credit card on file. We require a card on file, used per our Cancellation Policy, for unpaid balances, and for your treatments/purchases in limited circumstances.

HIPAA PRIVACY

We keep your health information confidential except as needed to provide care, run the practice, or as required by law. We may remind you of appointments and share practice updates by phone, text, email, or mail. You may request restrictions on the use of your information, and you have the right to access your records. Full policy available on request or at RejuvenationMDmedspa.com.

EMAIL & TEXT COMMUNICATION

Email and text are not fully secure. By signing below, I consent to receive appointment reminders and communication about my care via email/text. I understand I should call the office (and not rely on email) for anything urgent.

☐ I consent to email/text communication about my care. ☐ I decline (phone/mail only).

MARKETING (OPTIONAL)

I authorize RejuvenationMD to send me promotional/marketing material by email, text, or mail. This is voluntary and not required to receive services and can be revoked in writing at any time.

☐ Yes, I'd like to receive marketing communications. ☐ No thank you.

By signing below, I acknowledge that I have read, understand, and agree to all sections above.

Patient name (Please Print): _____

Signature: _____ **Date:** _____

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SKIN MATRIX

Name: _____Date: _____

Please answer the following questions by circling the number which best describes you.

My ethnic origin is closest to:	Very fair	0
	Fair-skinned with light hair and light eyes	1
	Pale-skinned with dark hair and dark eyes	2
	Olive-skinned	3
	Dark-skinned	4
	Very dark-skinned	5
My eye color is:	Light blue	0
	Blue / Green	1
	Green / Gray / Golden	2
	Hazel / Light brown	3
	Brown	4
My natural hair color at age 18 was:	Red	0
	Blonde	1
	Light brown	2
	Dark brown	3
	Black	4
The color of my skin that is not normally exposed to sun is:	Pink to reddish	0
	Very Pale	1
	Pale with a beige tan	2
	Light brown	3
	Medium to dark brown	4
	Dark brown - black	5
If I go out into the sun for an hour or so without sunscreen and have not been out in the sun for weeks, my skin will:	Burn, blister and peel	0
	Burn, then when it resolves there is little or no color change	1
	Burn, but then turns to tan in a few days	2
	Get pink, but then turns to tan quickly	3
	Just tan	4
	Just gets darker	5
	My skin color is very dark, therefore there is no color change	6
	Total:	

If your score is:	Your skin type is:
0 – 3	**1**
4 – 7	**2**
8 – 11	**3**
12 – 15	**4**
16 – 19	**5**
20 – 24	**6**
24+	