# New Patient Intake Form

Patient Name:_____ Date:_____

Street Address: _____ Sex: M / F

City:_____ State:_____ Zip Code:_____ Date of Birth:_____

Preferred phone number: _____ Email:_____

Emergency Contact: _____ Phone: _____ Relation: _____

**How did you hear about us**: Internet Website Facebook Instagram Radio Driveby

Client Referral: (Please specify name) _____ Other:_____

## Patient Concerns

| | | | | | |
|---|---|---|---|---|---|
| Lines/Wrinkles | ☐ Yes | ☐ No | Redness/Rosacea | ☐ Yes | ☐ No |
| Skin Laxity | ☐ Yes | ☐ No | Veins | ☐ Yes | ☐ No |
| Skin Texture/Scarring | ☐ Yes | ☐ No | Acne | ☐ Yes | ☐ No |
| Brown Spots/Hyperpigmentation | ☐ Yes | ☐ No | Dermatitis | ☐ Yes | ☐ No |
| Skin Growths | ☐ Yes | ☐ No | Other:_____ | ☐ Yes | ☐ No |
| Melasma | ☐ Yes | ☐ No | | | |

Are you interested in a specific procedure or service? ☐ No ☐ Yes:_____

What is your time frame for getting a procedure done? _____

## Cosmetic Procedure History

**Please indicate which treatments you have had previously:**

| | | | | | |
|---|---|---|---|---|---|
| Botox/Xeomin/Dysport/Jeuveau | ☐ Yes | ☐ No | Laser Hair Removal | ☐ Yes | ☐ No |
| Dermal HA Fillers: e.g Juvederm | ☐ Yes | ☐ No | PhotoFacial/IPL | ☐ Yes | ☐ No |
| Fillers: Sculptra, Artefill, | ☐ Yes | ☐ No | Vein Treatment (face or legs) | ☐ Yes | ☐ No |
| Collagen Laser Skin Resurfacing | ☐ Yes | ☐ No | Cellulite/Fat Loss | ☐ Yes | ☐ No |
| Laser Skin Tightening | ☐ Yes | ☐ No | Peels/Microderms/Facials | ☐ Yes | ☐ No |

☐ Cosmetic Surgery _____ Year_____

_____ Year _____

_____ Year_____

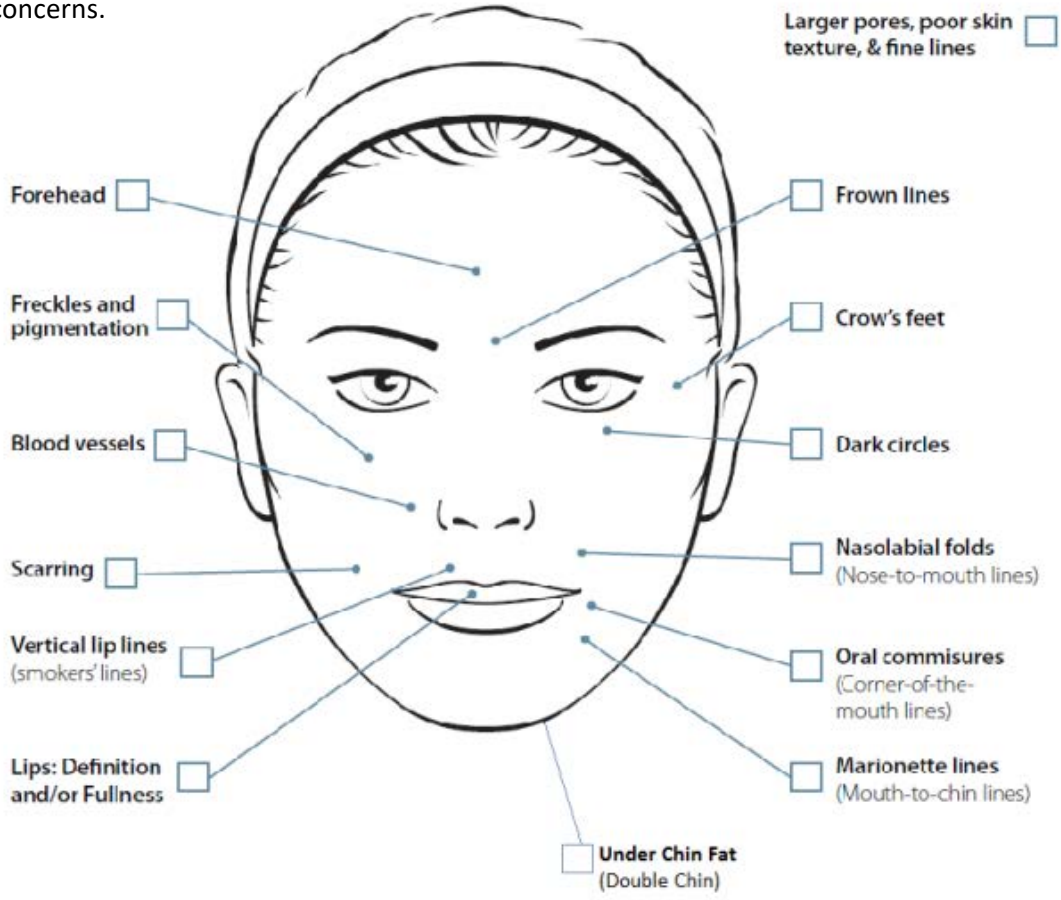
Adverse reactions to any of the above? ☐ No ☐ Yes _____

Where you pleased with your results? ☐ Yes ☐ No _____

# New Patient Intake Form

## Areas of Concern

With respect to facial aesthetics, please circle those areas of the face that bother or trouble you. In the box provided, please rate these areas on a scale of 1-5 (1 being least bothersome, 5 being most bothersom). Feel free to draw on the chart to identify any other concerns.




## Treatment Interest

**Please mark any services you would like to learn more about:**

_____ Wrinkle Relaxer (Botox/Xeomin/Dysport/Juveau)
_____ Injectable Wrinkle Fillers
_____ Lip Augmentation
_____ Collagen Biostimulator
_____ Novathreads (Facial Thread Lift)
_____ Laser Hair Reduction
_____ Brown and Red Spot Reduction
_____ Sclerotherapy (Leg Veins)
_____ Microneedling with PRP or Growth Factors
_____ Collagen Growth
_____ Hair Restoration
_____ Skin Tighten (Face, Neck, Chest, Buttocks, Arms, etc)
_____ Improve Skin Texture/Color
_____ Improve Tired Look
_____ Fat Reduction/Body Contouring (Stomach, Sides, Bra Line, Inner/Outer Thighs, Chin, Jawline)
_____ CoolSculpt
_____ Skin Tightening
_____ Excessive Sweating
_____ Joint Pain
_____ Weight Loss
_____ Hormone Therapy/Balancing
_____ Thyroid Optimization
_____ Genital Enhancement
_____ Scar Improvement
_____ Physician Grade Skin Care
_____ Semi-Permanent Cosmetic Tattoo (eyebrows, eyeliner, lips)
_____ Dermaplaning
_____ Facials
_____ Microdermabrasion
_____ Medical Grade Skin Peels
_____ Mineral Makeup
_____ Other: _____

# New Patient Intake Form

Boise Image Enhancement Centre

## Past Medical History

| | | | |
|---|---|---|---|
| Diabetes | ☐ Yes ☐ No | Hepatitis A/B/C/D | ☐ Yes ☐ No |
| Herpes or Cold Sores | ☐ Yes ☐ No | Neuromuscular Disorder/Bell's Palsy | ☐ Yes ☐ No |
| Active Implants: Pacemaker/Defibulator | ☐ Yes ☐ No | Hernia:_____ | ☐ Yes ☐ No |
| Metallic Implants | ☐ Yes ☐ No | Epilepsy/Seizures | ☐ Yes ☐ No |
| Hemorrhagic or bleeding disorders | ☐ Yes ☐ No | Autoimmune Disease | ☐ Yes ☐ No |
| Pregnant or Lactating | ☐ Yes ☐ No | High Blood Pressure | ☐ Yes ☐ No |
| Migraines | ☐ Yes ☐ No | Heart Disease | ☐ Yes ☐ No |
| Anxiety/Depression | ☐ Yes ☐ No | Liver Disease | ☐ Yes ☐ No |
| Neuropathy | ☐ Yes ☐ No | Immune Compromised/HIV | ☐ Yes ☐ No |
| Recent Dental Work | ☐ Yes ☐ No | IUD/Mesh Implants | ☐ Yes ☐ No |
| HIV/Aids | ☐ Yes ☐ No | Iodine/Latex Allergy _____ | ☐ Yes ☐ No |

**List any chronic Illnesses:** _____

**List any Drug Allergies:**_____

**Other Allergies we should be aware of:**_____

**Current Topical Creams/Ointments/Solutions**:_____

List all **medications and/or supplements** below. Be sure to include all prescription and non-prescription medications. If you are not taking any medications or supplements.

| Medication | Disease/Reason | Dose | Frequency | Date Started | Date last Taken |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

**Are you currently taking any of the following:**

| | | | |
|---|---|---|---|
| Anticoagulants or antiplatelet drugs | ☐ Yes ☐ No | Accutane within the last 12 months | ☐ Yes ☐ No |
| Immunosuppressant | ☐ Yes ☐ No | Anti-Inflammatories/NSAIDS | ☐ Yes ☐ No |

**Ethnicity/Ethnic Background:** _____(Important for Laser Treatments)

**Please check the one that applies the most:**

| | | | | |
|---|---|---|---|---|
| **Smoking History** | ☐ Never Smoked | ☐ Ex-Smoker | ☐ Light Smoker | ☐ Heavy Smoker |
| **Health** | ☐ No Health Issues | ☐ Minor Issues | ☐ Moderate Issues | ☐ Chronic Issues |
| **Sun Exposure** | ☐ Rarely In Sun | ☐ Occasionally in Sun | ☐ Frequently in Sun | ☐ In Sun Daily |
| **Alcohol Intake** | ☐ Never | ☐ Daily | ☐ Weekly | ☐ Occasionally/Socially |
| **Weight** | ☐ Rarely Fluctuates | ☐ Fluctuates Often | ☐ Plan on Losing | ☐ Currently Losing |
| **Sunscreen** | ☐ Never Use | ☐ Occasionally Use | ☐ Always Use | |

# New Patient Intake Form

## Patient Expectations

_____ **(Pt Initials)** I understand that cosmetic/aesthetic procedures are elective and are not meant to replace or substitute for surgical results.

_____ **(Pt Initials)** I understand that Boise Image Enhancement Centre, Inc recommends a consultation so they can provide a comprehensive plan to meet my goals.

_____ **(Pt Initials)** I understand Boise Image Enhancement Centre, Inc provides a multi-phase plan to meet my goals, but no guarantees or promises can be made for results*. There are many variables that are beyond their control that affect the procedure outcomes, especially individual expectations. Boise Image Enhancement Center, Inc maintains their equipment and continues staff education and training regarding technique. There are times when the human body does not respond as well as we would like. Lifestyle choices, diet, exercise, hydration, prior skin damage, sun exposure and many other factors affect the final results. All patients are unique and have unique needs and expectation. I will discuss my treatment expectations prior to my treatment.

_____ **(Pt Initials)** I understand that if the entire recommended plan is not completed, then my expectations should be re-evaluated.*

_____ **(Pt Initials)** I understand that I must wait 2 weeks after Botox/Xeomin/Dysport/Jeuveau or Filler injections to have a follow up with possible adjustments. This allows time for the products to work and for swelling to go down. However, I understand that follow ups and adjustments must be done no later than 3 weeks after my initial treatment.

_____ **(Pt Initials)** Botox/Xeomin/Dysport/Jeuveau follow ups and/or adjustments are at no charge for patients within the first three weeks; provided I purchased the recommended units made by the injector.

## Cancellation Policy

_____ **(Pt Initials)** Your time is reserved especially for you. We value your business and ask that you respect our scheduling policies. Should you need to cancel or reschedule, please notify us at least 24 hours in advance. Any cancellations with less than 24 hours notice will be subject to a cancellation fee. Clients who miss their appointments without giving any prior notification may be charged in full for the scheduled service. When you miss an appointment with us, we have clients on our pending cancellation list that would have liked to schedule an appointment for the same time. When you schedule your appointment with us, you are agreeing to these policies. All services require a credit card or gift certificate to guarantee a reservation so please have your credit card and/or gift certificate ready when booking. You will not be billed unless there is a last minute cancellation or no show. Upon checkout, guests may choose their method of payment.

## Payment Policy

_____ **(Pt Initials)** We are committed to the success of your medical treatment and care. Please understand that payment for your services is part of your treatment and care. You will be responsible for the FULL payment at the time of service. If a deposit is required, that will need to be paid prior to your scheduled appointment. If you need further information regarding our payment policy, please ask to speak with the practice coordinator.

**Patient Signature:**_____**Date:**_____

* Applicable for patients having consultations where a phased plan is developed to meet concerns