New Patient Intake Form

All information is confidential. Welcome to **Revive Skincare Clinic**! We are committed to providing you with unparalleled services and products. Please complete the following form as thoroughly as possible to help us achieve this goal. Thank you for choosing Revive Skincare Clinic! It is our pleasure to serve you.

Name (please print)______________________________________ DOB___________ Date_______________

Address____ City ________________ State Zip __________

Home Phone (______)_____________Cell Phone (______)____________Work Phone (______)________________

Email________________________________ May we add you to our email list? ___Yes ___ No thank you

Whom may we thank for your referral? ______________________________________

The following information is essential to optimize the results of your service:

Which concerns apply to your skin? Please check all that apply:

____ Anti-Aging
____Sensitivity /Redness
____Fine Lines
____Skin Laxity
____Acne
____Excessive Oiliness
____Scarring
____Unwanted Hair
____Dark Spots (Hyperpigmentation)
____ Uneven Skin Tone
____Dryness
____ Clogged Pored
____ Stretch Marks
____ Cellulite
____Please List Other Concerns: ____

Please check the skincare products you currently use and their brand names:

____Cleanser ______________ _____ Toner_________________ ____ Exfoliant__________________

____Serum ________________ ____Moisturizer/Day ______________Moisturizer/Night_________________

____Eye Cream _____________ _____ SPF _________________ ____Other ____________________

Please check the medications/supplements you are currently using:

___ Accutane ___Differin ___Retin A, Renova ___ Tazorac ___Antibiotics (Oral or Topical)

___ Fish Oil ___ Vitamin E ___ Ginko Biloba ___ Ginseng ___ Wine/Alcohol

___Other Please List ____

Are you allergic to any cosmetic ingredient, medication or food? Please List:

____

____

In the past 30 days, please list all professional facial or dermatology services you have received (i.e. Chemical Peel, Microdermabrasion, Laser, Botox ®, other cosmetic injectibles, etc.):

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Please take a moment to carefully read the following list of conditions and check any that have affected your health either recently or in the past:

____ Wearing Contact Lenses
____ Herpes Virus (i.e. cold sore, fever blister)
____ Skin Cancer Where/When: ________________
____ Thyroid (over or under active)
____Diabetes
____Metal implants. Location: __________
____Surgeries What/When? _______________
____Sinus Infection
____ Contagious Conditions____
____ Pregnant –Which Trimester?_____________
____ Hormonal Therapy____
____ High or Low Blood Pressure
____ Heart Condition / Pacemaker
____ Epilepsy or Seizures
____ Tension Headaches / Migraines
____ High level of Stress
____ Pacemaker

Are there other Medical Spa/Laser services that you would you like more information about?

____

All of the above information is true and accurate to the best of my knowledge. I take full responsibility for alerting my Physician/Esthetician to any physical or mental condition which would affect my service or results. I understand my treatment is therapeutic in nature and will alert my Physician/Esthetician to any discomfort.

(Initials: ________)

Please Read and Sign the Back of the Form

Waiver. I understand and acknowledge there are risks involved with the treatment of facials, peels, microneedling, microcurrent and laser skin treatments. I have had the opportunity to ask questions regarding these risks and other possible complications. I understand any false or misleading information I have given may lead to undesired results and complications and hereby waive Revive Skincare Clinic and the Physician/Esthetician's liability if such results or complications occur. I further understand my failure to follow post care instructions may also lead to undesired results, complications, or effects and hereby waive Revive Skincare Clinic's and the Physician/Esthetician's liability if such results or complications occur. In consideration for Revive Skincare and the Physician/Esthetician's performing this procedure, I agree I will assume the risk and full responsibility for any and all injuries, losses, or damages, which might occur to me while I am undergoing this procedure or side effects I may experience after the procedure is performed. I understand that the Physician/Esthetician's does not diagnose illness, disease, or any other physical or mental conditions. Any sexual misconduct exhibited by the Client will result in immediate termination of the session, and the client will be liable for payment of the scheduled appointment. To the maximum extent allowed by law, I agree to waive and release any and all present and future claims, suits or related causes of action against the Physician/Esthetician, Revive Skincare, it's service providers, owners, officers, employees, or agents for negligence, injury, loss, death, costs or other injuries or damages to me as a result of this procedure. I agree this waiver and release shall bind the members of my family and any spouse or domestic partner, if I am alive, as well as my estate, family, heirs, administrators, personal representatives or assigns if I am deceased, and shall be deemed as a "Release, Waiver, Discharge and Covenant" not to sue Revive Skincare Clinic or any of it's service providers.

MAXIMUM LIABILITY. THE HEALING TREE'S MAXIMUM AGGREGATE LIABILITY TO PATIENT RELATED TO OR INCONNECTION WITH THE PROCEDURE PERFORMED BY THE REVIVE SKINCARE CLINIC, ITS EMPLOYEES, OR AGENTS WILL BE LIMITEDTO THE TOTAL AMOUNT PAID TO THE HEALING TREEBY PATIENT FOR THE PROCEDURE DESCRIBED IN THISAUTHORIZATION AND CONSENT.

______________________________	______________________________	______________
Client Signature	Printed Name	Today's Date
______________________________	______________________________	______________
Signature Parent/Guardian if under 18	Printed Name	Today's Date