# The Skin Retreat

10801 Executive Center Drive Suite 101 / Little Rock, AR 72211 / (501) 492-8970

Today's Date: ______________

Patient Name: ________________________________________ Date of Birth: ______________

Address: ____________________________________________________________________________

Email: ____________________________________________ Phone: ______________________

Would you like to receive monthly emails with our discounts, specials, and promotions?
**Yes** **No**

Any Known Allergies: ____________________________________________________________

Do you have a milk allergy? **Yes** **No**

Current Medications: ____________________________________________________________

Have you recently taken Aspirin or Ibuprofen? **Yes** **No**
If yes, when? ___________________________________

Do you use nicotine products: **Yes** **No**
If yes, what type & how often? _____________________________________________________

Do you experience skin break outs? **Yes** **No**
if yes, how often?_______________________________

Is your skin: **Dry** **Oily** **Normal** **Sensitive**

Do you have any pigmentation problems? **Yes** **No**
If yes, where?___________________________________

Do you have a history of fever blisters? (even if you have only had one) **Yes** **No**

Do you have a history of Accutane therapy? **Yes** **No**
If yes, when was last use? _______________________

Do you have a history of any medical problems? **Yes** **No**
If yes, please list medical problem & treating physician: _________________________________

______________________________________________________________________________________

Have you ever had a facial peel? **Yes** **No**
If yes, when was the last time? ____________________

Have you ever used glycolic acid, Retin-A, or Retinol products? **Yes** **No**
If yes, when was last use? ______________________

Do you have a history of scarring? **Yes** **No** Keloids? **Yes** **No**

Have you had any of the following? (please circle all that apply)

**Recent Waxing** **Electrolysis** **Laser** **Sun Exposure** **Surgery**

Have you ever had skin cancer or precancerous lesions? **Yes** **No**
If yes, where? ______________________________

Have you ever had any problems with lidocaine? **Yes** **No**
If yes, explain: ______________________________

Have you had surgery or implants in the area to be treated? **Yes** **No**
If yes, explain: ________________________________________________________

________________________________________________________________________

What skin care products are you currently using? __________________________________

________________________________________________________________________

Do you use sunscreen on a daily basis? **Yes** **No**

Do you tan indoors and/or outdoors? **Yes** **No**
If so, which one? ______________________ When was the last time? _______________

Self-tanner? **Yes** **No**

Please Circle your appropriate skin type below: (Fitzpatrick Scale)

| **Skin Color** | **Reaction to the sun** | **Skin type** |
|---|---|---|
| Very white or freckled | Always burn | I |
| White | Usually burn | II |
| White or olive | Sometimes burn | III |
| Brown | Rarely burn | IV |
| Dark brown | Very rarely burn | V |
| Black | Never burn | VI |

What is your genetic origin? (please circle all that apply)
**African American** **Asian** **Caucasian** **Hispanic** **Mediterranean** **Middle Eastern**
**Native American** **Other:** ______________________

Please indicate which of the following concerns you have about your skin: (please circle all that apply)

| | | | |
|---|---|---|---|
| **Aged Skin** | **Enlarged Pores** | **Blackheads** | **Age Spots** |
| **Acne** | **Wrinkles** | **Whiteheads** | **Texture** |
| **Redness** | **Unevenness** | **Oily skin** | **Melasma** |
| **Scarring** | **Hyper Pigmentation** | **Dry Skin** | **Stretch Marks** |
| **Sun damage** | **Rosacea** | **Sensitive Skin** | **Isolated Fat Areas** |

What area would you like to treat? (please circle all that apply)

**Face** **Neck** **Chest** **Hands** **Other:**____________________

Please indicate the service or services you are interested in or would like more information about:

| | | |
|---|---|---|
| **Laser Skin Rejuvenation** | **Pigment Treatment** | **Wrinkle Treatment** |
| **Rosacea Treatment** | **Sun Damage Repair** | **Botox Cosmetic** |
| **Dysport** | **Filler Injections** | **Stretch Mark Treatment** |
| **Scar Treatment** | **Redness** | **Acne Treatment** |
| **Age Spot Treatment** | **Melasma** | |

What improvements would you like to see in your skin? ____________________

______________________________________

______________________________________

**EMERGENCY CONTACT INFORMATION:**

Name: ________________________ Phone: ________________

____________________________

Signature of Patient or Legal Guardian

____________________________ ________________

Print Patient Name Date

____________________________ ________________

Witness Date

# RELEASE OF INFORMATION

PLEASE READ EACH CONSENT/AUTHORIZATION BELOW & SIGN AT THE BOTTOM OF THE PAGE

### CONSENT FOR PHOTOGRAPHIC DOCUMENTATION

I consent to be photographed before, during, and after my treatment, operation, etc. recommended by Shewmake Plastic Surgery & Skin Retreat. These photographs shall be the property of Shewmake Plastic Surgery & Skin Retreat. I understand that every effort will be made to protect my identity. THESE PICTURES ARE FOR IN OFFICE USE ONLY. YOUR PICTURES WILL NOT BE POSTED ON THE INTERNET OR USED IN ANY OTHER WAY WITHOUT YOUR CONSENT.

### CONSENT FOR SELF-PAY PATIENTS

I understand and agree that any and all charges incurred by me shall be paid in full to Shewmake Plastic Surgery & Skin Retreat.

**Signature:**________________________________________ **Date:**____________________

## SHEWMAKE PLASTIC SURGERY & SKIN RETREAT
## PATIENT CONSENT FOR USE OF CREDIT CARD, DEBIT CARD, AND FINANCING
## DISCLOSURE OF PROTECTED HEALTH INFORMATION

It may become necessary to release your protected health information to financial parties, credit card entities, banks, and financing companies, when requested, to facilitate your payment.

Services that are performed that are paid with a credit card, debit card, or financing third-party are not eligible for payment challenges after services are provided. By signing this form, I am irrevocably consenting to allow Shewmake Plastic Surgery & Skin Retreat to use and disclose my protected health information to any Credit Card Entity, Bank, or Financing Company when they request such information to process an account and assist with payment.

__________ I will not challenge such credit, debit, or financing card payments once the services are provided. Shewmake Plastic Surgery & Skin Retreat encourages complete post-op care and follow-up interaction to address any issues that might arise.

__________ I agree that this non credit card challenge agreement is irrevocable.

____________________________________
Signature of Patient or Legal Guardian

____________________________________ ____________________
Print Patient Name Date

____________________________________ ____________________
Witness Date

*NOTE: If you do not sign, you may not use a credit, debit, or Care Credit financing. All payments must be made with cash, check, money order or cashier's check.*