CapitalCare Family

MedEsthetics

1882 New Scotland Rd., Suite 200
Slingerlands, NY 12159
518-429-2909

Name:_______________________________ DOB:_______________

Address:____

Home Phone:______________ Work Phone:______________ Cell Phone:________________

Preferred daytime phone (circle one): Home Work Cell

Permission to send you **promotional** text messages? Yes No
Permission to send you **appointment reminder** text messages? Yes No

Email Address:______________________________________
Permission to send you **promotional** emails? Yes No
Permission to send you email **appointment reminders**? Yes No

Occupation:_________________________

Marital Status: **S M D W** Spouse Name:__________________ Anniversary Date:______________

Emergency Contact:___________________________ Relationship:___________Phone:_____________

Reason for visiting us today: ____

How did you hear about us? :

- Newspaper
- Magazine
- Website
- Friend/Family Member
  Who may we thank for referring you to us? ______________________
- Other
  Please specify ______________________________

The services provided by CapitalCare Family MedEsthetics are considered cosmetic and will not be filed with any insurance plan. Your decision to have this service rendered indicates an understanding that our services are NOT medically necessary, and therefore you are responsible for payment.
All cosmetic services are to be paid in full at the time of service.

Medical History

Primary Care Physician: ______________________________

Are you currently under the care of a dermatologist? ☐ Yes ☐ No Name: ____________________________

If yes, for what: ____

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

☐ Cancer	Frequent Cold Sores	Seizure Disorder
☐ Diabetes	HIV/AIDS	☐ Hepatitis
☐ High Blood Pressure	Keloid Scarring	Skin Disease/Lesions
☐ HSV	Hormone Imbalance	Thyroid Imbalance
☐ Arthritis	Blood clotting abnormalities	Any Active Infection

Do you have any other health problems or medical conditions? If yes, please list:

____

Allergies

List any **drug**, **makeup**, **skin** or **food** allergies (including soaps, cleansing creams, etc.):

____

Latex Allergy? : ☐ Yes ☐ No

Social History

Use of Alcohol: ☐ Never ☐ Rarely ☐ Moderately ☐ Daily

Use of Tobacco: ☐ Never ☐ Quit (year_____) ☐ Current Use (packs/day____)

Medications

Are you currently taking aspirin, Plavix, Coumadin, blood-thinners, Ibuprofen, or any other anti-inflammatory drug?

If so, please list:____

List all medications/supplements you are currently using. Include vitamins, herbs, weight loss products, Retin A, and Accutane:

____

Skin Care History

Which of the following best describes your skin? Check all that apply:

☐ Normal	☐ Oily	☐ Acne Prone	☐ Eczema
☐ Dry	☐ Combination	☐ Rosacea	☐ Psoriasis

Which skin care product line are you currently using?:____________________________

Have you ever had any of the following treatments? Circle all that apply:

☐ Botox	☐ Pigmented Lesions	☐ Facials	Dermal Filler
☐ Hair Removal	☐ IPL/Laser	☐ Electrolysis	Photofacial
☐ Chemical Peel	☐ Leg Spider Veins☐	Microdermabrasion	

☐

Please use this space to note any esthetic concerns or any additional information you would like us know:

____

____

Signature:_____________________________Date:_______________ Reviewed By: __________________________