

**Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Todays Date**:\_\_\_\_\_\_\_\_\_\_\_ **Date of Birth:** \_\_\_\_\_\_\_\_\_\_ **Sex:** M/F

**Home Phone**: ( ) \_\_\_\_\_\_\_\_ - \_\_\_\_\_\_\_\_\_\_ May we leave voice or text messages regarding appts? **🞏**Yes **🞏**No

**Cell Phone**: ( ) \_\_\_\_\_\_\_\_ - \_\_\_\_\_\_\_\_\_\_ May we leave voice or text messages regarding appts? **🞏**Yes **🞏** No

**Street Address**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **City**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **State**: \_\_\_\_\_\_\_ **Zip**: \_\_\_\_\_\_\_\_\_\_

**E-Mail**: \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (we send discount notifications through email)

**Emergency Contact:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Cell Phone:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Can we release information to your emergency contact? **Circle one:** Yes / No **Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Circle how you heard about Ultimate Image:**

Website**/** Web search: Keyword: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Friend Referral (Name of Friend):

Magazine/Television/Groupon/Event: Other:

**Circle Skin Type:** Fair Skin-Blonde**/**Fair Skin-Brunette**/**Average Skin**/**Olive Skin-Hispanic**/**Dark Skin-Middle East**/**Black

**Circle If You have ever had:** Keloid **/** Accutane **/** Cold Sores **/** Fever Blisters **/** Shingles **/** Herpes **/** HIV **/** Hepatitis **/** Fibromyalgia **/** Yeast **/** Headaches **/** Chronic Pain **/** Chronic Fatigue Syndrome **/**Epstein Barr **/**Depression **/** Anxiety **/** Bipolar **/** Irritable Bowel

**List any other medical problems**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**List current medications & supplements:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**List current skin care products**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**List all allergies**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**List cosmetic procedures you have had:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**What is your main Cosmetic Concern(s)?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Occupation:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Check which procedures you are interested in:**

**🞏 DUAL Fraxel 1550/1927 Treatments -** For brown spots, redness, wrinkles, acne scars, & firms the skin;

**🞏 Botox** or **Dysport -** Relaxes brow, eye, & forehead wrinkles; **🞏 FILLER -** Fills lines around face; **🞏 PRP-** Platelet Rich Plasma; **🞏 ThermiTight Lipo-** Liposuction;  **🞏Verju** **-** Cellulite & Body Sculpting; **🞏 Liposonix -** Non-Surgical Fat Removal; **🞏 Laser Hair Removal; 🞏 Vein "Removal";** **🞏 Rx Weight Loss Program;**

**🞏 Levulan & Blu-Light** **-** Reduces Acne; **🞏 Esthetician Services -** Facial, Peels, Microderm;

**🞏 Minor Surgery** **-** Scar or mole removal

**I acknowledge I received a copy of the Privacy Policy of Ultimate Image Cosmetic Medical Center. I am not pregnant or breast feeding**. I realize that if I become pregnant, I should not have any cosmetic procedures and should stop using all medications and skin care products until I am given permission to use them by my Obstetrician. If I become pregnant I will notify Dr.Besnoff both in writing & verbally and cancel any appointment or procedure. **I have listed all of my current medical problems and medications on the patient information form**. If in the future I develop any new medical problems or start taking any new medications, I will inform Dr. Besnoff in writing & Verbally prior to any appointment or procedure. I understand that Dr. Besnoff cannot give me the proper treatment, nor be held responsible, if I do not disclose up to date information about my health. **I consent to have before/after treatment pictures and television filming of any and all procedures by Todd A. Besnoff, MD.** I give my permission for Dr. Besnoff to use the pictures and film for medical, educational and advertisement purposes. I realize that I will not be compensated for the use of the pictures.

Patient’s Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Patient’s Printed Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_

Witness’s Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Witness’s Printed Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_