



Patient Form & Confidentiality Agreement

April 16, 2019

Institute of Epidermal Cell Therapy
Document Sender : Michelle Bechtel

Patient Form & Confidentiality Agreement

Confidential Patient Information

Patient Name:

Address:

Email:

Daytime Phone: Cell phone:

Occupation:

Dermatologist:
Physician:

Emergency Contact:

Referred by:

Is this your first facial? If not, when was your last facial?
Is this your first body treatment: If not, when was your last body treatment?

What is the reason for your visit today?
What special concerns do you have?

Are you currently under a physician's care for any skin conditions?
If so, what condition specifically and for how long:

Have you had a recent operation? If so, please describe:
Were any medications prescribed?
Are you still on medication?
If so, what kind? What is the dosage?
Is the area of the operation still sensitive to different temperatures or amounts of pressure?

What is the date of your last gynecological visit? Which of the following procedures did you have at your last exam?

Are you pregnant? If so, how far along? Are you (will you be) nursing?

Are you taking birth control? If so, what kind and for how long? Have you seen any changes in your skin since you started using it? If you have, what changes have you seen?

Are you on hormone replacement therapy? If so how has your skin adjusted to it?

Have you had any problems with moisture loss/becoming drier in any areas?

Date of last dental exam: Were dental x-rays required?

Do you wear contact lenses?

Do you smoke? If so, how much and how often? Where do you normally smoke?
If you DO NOT smoke, are you around smoke while at: If yes, how often are you around it?

Do you have difficulty managing stress?

Do you or have you had cancer? If so, what type and where?
When was it discovered? When was your last treatment?
What kind of treatment was it?
Has anyone in your family ever been diagnosed with cancer?
If so, how are they related to you?



Are you using (or used): If so, how long? What are you using it for?
Have you noticed a difference? If so, what?
Do you have any concerns with the use of this product? If so, what?

Do you have acne or experience frequent blemishes? How frequently:

Do you have any allergies? If so please list:
Are you taking allergy medications? If so please list:

Are you taking any medications not listed above? If so, please list:

What products do you presently use for face & body?
What brand/line are these products?
How do these products seem to be working for you? How often do you use these products?
What is the SPF in any sunscreens you may be using?
Do you take: If so, what kind and how often?
Have you noticed a difference in anything?

Daily water consumption?
Daily caffeine consumption?
How often do you exercise?

Please check if you are affected by or are currently experiencing any of the following:
Please explain any of the above, including treatments or any significant others not mentioned:

Please list any known allergies:

Patient Agreement

I understand that the services offered are not a substitute for medical care and any information provided by the esthetician is for educational purposes only and not diagnostically prescriptive in nature. I further understand that the information herein is to aid the esthetician in giving the most appropriate and safe treatment available and remains confidential.

Date

Client Signature

--OR--

Consent to administer treatment for Minor/Dependent: Parent/Guardian Signature

X _____

Signature Certificate

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This audit trail report provides a detailed record of the online activity and events recorded for this contract.