MILL CREEK
SKIN & LASER
CENTER

425-316-8200

New Patient Consultation Form

Today's Date: _____ ***How did you hear about us*:** _____

First Name: _____ **M.I**. _____ **Last Name:** _____

Address: _____

City: _____ **State**: _____ **Zip Code:** _____

Date of Birth: _____ **Occupation:** _____

Preferred Contact Phone #: _____ **Is this your**: [Home] [Cell] [Work] number?

Alternate Contact Phone #: _____ **Is this your**: [Home] [Cell] [Work] number?

Email: _____ for ☐ Appointment Reminders ☐ Promotional

Emergency Contact: _____ **Relationship:** _____ **Phone:** _____

MONTHLY MEMBERSHIP – Sign up today for a better, brighter and healthier appearance tomorrow!

Our monthly membership program is an affordable and convenient way for our patients to achieve and maintain pro-active results, and to further improve your skin's health and esthetic appearance**.**

Would you like to know more? [Yes] [No] [Not at this time]

Do you have a budget in mind? ❑ $500-$1000 ❑ $1000-$3000 ❑ $3000-$5000 ❑ $5000-$12,500 ❑ $12,500+

Upcoming Event? Date: _____ Type: _____

Reason for visit? (Check all that apply):

- ❑ Acne / Acne Scarring
- ❑ Excessive Oilness
- ❑ Spider Veins
- ❑ Wrinkles / Aging Skin
- ❑ Double Chin
- ❑ Hair Removal
- ❑ HydraFacial
- ❑ Blackheads / Whiteheads / Clogged Pores
- ❑ Brown/Sun Spots (Hyperpigmentation)
- ❑ Stretch Marks
- ❑ Skin Laxity / Sagging Skin
- ❑ Injectables
- ❑ Tattoo Removal
- ❑ Eyebrow/Lash Tinting / Waxing
- ❑ Hard bumps under skin
- ❑ Redness / Rosacea
- ❑ Scar - area: _____
- ❑ Upper Lip Lines
- ❑ Unwanted Body Fat
- ❑ Vaginal Rejuvenation
- ❑ Other _____

Would you like us to teach you how to take care of your skin? ☐Yes ☐ No

Have you ever done a treatment for any of the above or other type of cosmetic/surgical procedure? If so, please list:

Treatment Type	Area	When?	Where?

I II III IV V VI F M Entered By: _____ Follow-up: _____

Have you ever had or are currently being treated for cancer? ❑NO ❑YES
If so, what type?: _____

If so, are you taking any medications for this? ❑NO ❑YES
If so, please list: _____

Do you have immuno-compromised condition? (transplant, history of splenectomy, etc.) ❑NO ❑YES
Are you taking immune-suppressants? (Steroid, Prograft, Azathioprine, Cyclosporine, etc.) ❑NO ❑YES
Do you have an autoimmune disorder? (Lupus, etc.) ❑NO ❑YES

Medications: Are you currently taking any medications/herbal supplements/vitamins? ❑NO ❑YES

If yes, please list:	For:
_____	_____
_____	_____
_____	_____

Skin History: Have you ever visited a Dermatologist? ❑NO ❑YES
If yes, for what reason/treatment?

Are you pregnant or breastfeeding?* ❑NO ❑YES
**Note: Treatments are limited when patient is pregnant or breastfeeding.*

Are you taking any blood thinners? ❑NO ❑YES
(Plavix, Coumadin, Fragmin Pradaxa, Lovenox, Xarelto etc.)

Do you have a pacemaker or defibrillator? ❑NO ❑YES
Do you smoke? ❑NO ❑YES ❑ How Many? _____
Do you drink alcohol? ❑NO ❑YES ❑ How Often? _____

Do you have any of the following allergies: ❑ Shellfish ❑ Aspirin ❑ Salicylic Acid ❑ Sulfur ❑ Zinc ❑ OTHER
Please list: _____

Are you currently using Retin-A or retinoid products? ❑NO ❑YES
If yes, date of last use: _____

Are you currently using products that contain Glycolic Acid or AHA? ❑NO ❑YES
If yes, how long have you been using the product? _____
How has your skin reacted? _____

Have you been on Accutane in the past 12 months? ❑NO ❑YES
Date of last use: _____

Do you actively (laying in sun / tanning beds?) "seek a tan?" ❑NO ❑YES ❑ How Often? _____
Do you regularly use sunscreen? ❑NO ❑YES
Have you ever had blistering sunburns? ❑NO ❑YES
When exposed to the sun, do you: ❑Tan only ❑Tan and Burn ❑Burn ❑None

General Medical: Do you now have, or have you ever had:

Asthma	❑NO ❑YES	Seizures	❑NO ❑YES	Arthritis	❑NO ❑YES
Seasonal allergies	❑NO ❑YES	Depression	❑NO ❑YES	Ulcers/Reflux	❑NO ❑YES
High BP	❑NO ❑YES	Thyroid Disease	❑NO ❑YES	Liver Pbl/Hepatitis	❑NO ❑YES
Phlebitis	❑NO ❑YES	Diabetes	❑NO ❑YES	HIV Infection/AIDS	❑NO ❑YES
Heart Valve Dis.	❑NO ❑YES	Glaucoma	❑NO ❑YES	Heart Condition	❑NO ❑YES
Blood Clots	❑NO ❑YES	Cataracts	❑NO ❑YES	Hernia	❑NO ❑YES
Keloid Scarring	❑NO ❑YES	Herpes/Cold Sores	❑NO ❑YES	Chronic Sinuitis	❑NO ❑YES
Rosacea	❑NO ❑YES	OTHER:_____			

Do you have any known sensitivity to cold such as cold urticaria or Raynaud's disease? ❑NO ❑YES

Photo Policy - We reserve the right to take photographs, which are strictly for medical records only. A $30 processing fee will be charged for patients that want copies of their photos.

Payment Policy - Full payment for services rendered must be received **PRIOR** to treatment. We accept Visa, Mastercard, Debit Cards, Care Credit* and Cash. **We do not accept checks.**

Appointments and Cancellation Policy - We recognize that everyone's time is valuable, so we make every effort to maintain the scheduled appointment times, but urgent situations sometimes disrupt the schedule. We ask for your understanding and patience during these delays. We will make every effort to keep your waiting time to a minimum.

If you are unable to keep your appointment, please call. Late arrival may necessitate rescheduling your appointment. The first two appointments not kept, cancelled, and/or not rescheduled **at least 48 hours** prior to the scheduled appointment time **will be charged $50.00 each.** The third and all subsequent appointments not kept, cancelled, and/or rescheduled at least 48 hours prior to the scheduled appointment time **will be charged $100 each.** Missed appointment fees must be paid at the next scheduled appointment.

Child Care Policy - We do not offer child care. Mill Creek Skin & Laser can be a dangerous environment for unsupervised children. We do not allow your children to be unsupervised at any time. For the safety of your children, we recommend you make alternative arrangements for the care of them. We reserve the right to reschedule your appointment if you do not have proper child care. We apologize for any inconvenience this may cause you but this is for the safety and protection of your children.

*****Mill Creek Skin & Laser reserves the right to refuse service to anyone*****

Patient Signature: _____ Date: _____

Guardian Signature: (if patient is under 18): _____ Date: _____

FOR OFFICE USE ONLY

Laser Hair Removal: **Recommended # of Treatments**:_____ **Every** _____**weeks**

Area	***Price Per Treatment***

Comments:_____

Stretch Marks: **Recommended # of Treatments**:_____ **Every** _____**weeks**

Area	***Price Per Treatment***

Comments:_____

Tattoo Removal ***Price Per Treatment*** **Every** _____**weeks**

Area		**Pico**	**+ Affirm**	**+ CO2**	

Comments:_____

MILL CREEK SKIN & LASER CENTER
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