

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	<input type="checkbox"/> NO <input type="checkbox"/> YES	Seizures	<input type="checkbox"/> NO <input type="checkbox"/> YES	Arthritis	<input type="checkbox"/> NO <input type="checkbox"/> YES
Seasonal allergies	<input type="checkbox"/> NO <input type="checkbox"/> YES	Depression	<input type="checkbox"/> NO <input type="checkbox"/> YES	Ulcers/Reflux	<input type="checkbox"/> NO <input type="checkbox"/> YES
High BP	<input type="checkbox"/> NO <input type="checkbox"/> YES	Thyroid Disease	<input type="checkbox"/> NO <input type="checkbox"/> YES	Liver Pbl/Hepatitis	<input type="checkbox"/> NO <input type="checkbox"/> YES
Phlebitis	<input type="checkbox"/> NO <input type="checkbox"/> YES	Diabetes	<input type="checkbox"/> NO <input type="checkbox"/> YES	HIV Infection/AIDS	<input type="checkbox"/> NO <input type="checkbox"/> YES
Heart Valve Dis.	<input type="checkbox"/> NO <input type="checkbox"/> YES	Glaucoma	<input type="checkbox"/> NO <input type="checkbox"/> YES	Heart Condition	<input type="checkbox"/> NO <input type="checkbox"/> YES
Blood Clots	<input type="checkbox"/> NO <input type="checkbox"/> YES	Cataracts	<input type="checkbox"/> NO <input type="checkbox"/> YES	Hernia	<input type="checkbox"/> NO <input type="checkbox"/> YES
Keloid Scarring	<input type="checkbox"/> NO <input type="checkbox"/> YES	Herpes/Cold Sores	<input type="checkbox"/> NO <input type="checkbox"/> YES	Chronic Sinuitis	<input type="checkbox"/> NO <input type="checkbox"/> YES
Rosacea	<input type="checkbox"/> NO <input type="checkbox"/> 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**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Comments: \_\_\_\_\_

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