BOUTIQUE AESTHETICS
LASER & VEIN CENTER OF MSPB

PLEASE COMPLETE ALL INFORMATION

Name: Last _____First _____ MI_____

Date of Birth: _____

Address_____

_____

Apt _____ City _____ State _____ Zip _____

Email Address _____

Phone# (Best number to reach you) (____) _____

Can we leave a message on this number? ☐ YES ☐NO

How did you hear about us?

- ☐ Another client. Who may we thank? _____
- ☐ Our website.
- ☐ Social media. Which one? _____
- ☐ A staff member. Name: _____
- ☐ Other _____

Procedures or issues of interest to you: (please check all that apply)

- ☐ Botox product/Wrinkle Relaxer
- ☐ Dermal fillers
- ☐ SculpSure/Body contouring /Skin tightening
- ☐ Laser skin resurfacing (1540)
- ☐ Laser hair removal
- ☐ ThermiVa - Non-surgical feminine rejuvenation
- ☐ Acne or acne scarring
- ☐ PRP for Hair Loss
- ☐ Facials
- ☐ Vampire Facial
- ☐ Chemical peel
- ☐ Microdermabrasion
- ☐ Micro-needling/SkinPen
- ☐ Radio Frequency Microneedling
- ☐ Photo-Facial (IPL)
- ☐ Skin care products

COSMETIC QUESTIONNAIRE

NAME:_____ DATE OF BIRTH:_____ DATE: _____

Select which areas of the face concern you on the diagram below.

By sharing how you see yourself, we can best evaluate your aesthetic goals and select an appropriate treatment for you.

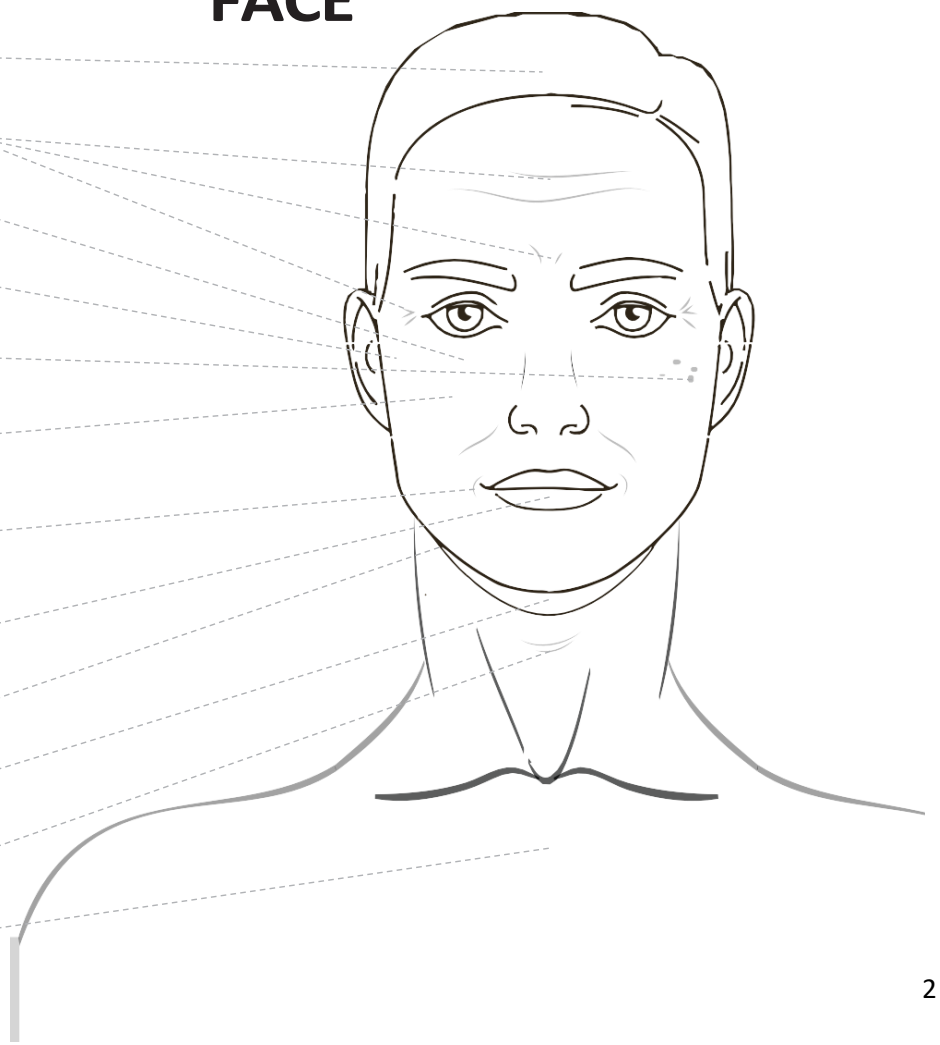
BODY

- ◯ Hair Removal
- ◯ Cellulite
- ◯ Spider Veins
- ◯ Scars
- ◯ Excessive Sweating
- ◯ Unwanted Fat
- ◯ Sagging Skin

◯ Other: _____

FACE

- ◯ Thinning Hair
- ◯ Wrinkles
- ◯ Sunken Under Eyes
- ◯ Sagging or Sunken Cheeks
- ◯ Sun Damage/Brown Spots
- ◯ Redness/Rosacea
- ◯ Lines & Wrinkles Around Nose & Mouth
- ◯ Thin Lips
- ◯ Sagging Jowls
- ◯ Fullness Under Chin
- ◯ Sagging Neck
- ◯ Wrinkles



PERSONAL INFORMATION

Name _____ Date _____

Emergency Contact Name & Phone:

_____

MEDICAL HISTORY

Name of your primary care physician: _____

Name of your dermatologist: _____

Do You Have any of the following medical conditions? (Please check all that apply)

☐ Herpes ☐ HIV /AIDS ☐ Keloid Scarring ☐ Skin disease/Skin lesions ☐ Hepatitis

☐ Hormone Imbalance ☐ Thyroid Imbalance ☐ Blood Clotting Abnormalities

Do you have any other health problems or medical conditions? Please list: _____

_____

_____

Have you ever had an allergic reaction to any of the following?
(Please check all that apply & describe the reaction you experienced)

☐Latex ☐Lidocaine ☐Hydroquinone

☐Other: _____

Type of Reaction: _____

MEDICATIONS

What oral medications are you currently taking? (Please list):

_____

Are you on any mood altering or anti-depression medication? ☐ YES, _____ ☐NO

Have you ever used Accutane? ☐ YES ☐NO If yes, when did you last use it? _____

Have you ever used RetinA? ☐ YES ☐NO

What herbal supplements do you use regularly? _____

FOR OUR FEMALE CLIENTS

Are you pregnant or trying to become pregnant? ☐ YES ☐NO

Are you breastfeeding? ☐ YES ☐NO

Are you using contraception? ☐ YES ☐NO

Are you using Hormones? ☐ YES ☐NO

I certify that the preceding medical, personal and skin history statements are true and correct, I am aware that it is my responsibility to inform the technician, esthetician, therapist, doctor or nurse of my current medical or health conditions and to update this history. A current medical history is essential for the caregiver to execute appropriate treatment procedures.

Signature: _____ Date: _____

MISSED/LATE APPOINTMENT FEE

I understand that Dr. Vanden Bosch strives to treat all patients at their scheduled times and that I must provide at least 24 hours notice if I need to reschedule or am unable to make my appointment. A cancellation fee of $50.00 will be charged if appointment is not cancelled within 24 hours of service. I understand that if I frequently miss appointments or am frequently late for appointments then a credit card may be required to book future appointments.

CONSENT FOR ADDITIONAL TREATMENT/ TOUCH-UP

At V Boutique, we have invested in you. Our goal is to achieve the optimal result in the safest, fastest way with the least number of treatments necessary.

As everyone's individual body and chemistry differ, people often respond differently to treatments. Your first session doing a new procedure may sometimes be the session where we find your ideal treatment protocol. Laser energy settings and aesthetic injectable amounts vary and we will customize what will best suit your needs. Once we know this, similar treatments will be standardized for your convenience.

Dr. Vanden Bosch's conservative approach and expertise leaves patients looking refreshed and rejuvenated without looking altered or overdone. We will strive to minimize the number of treatments required, to save you time and money. Our main goal is to safely achieve your optimal results.

Many cosmetic procedures will take more than one session to safely achieve superlative, natural looking results, while others require just one treatment. Please be advised that additional treatment variations may be necessary.

I do understand that a follow-up/ touch-up appointment may be necessary, and I will be billed at normal fees.

_____ _____

Printed Name of Patient (or legal guardian) Date

_____ _____

Signature of Patient (or legal guardian) Staff Signature/Witness

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PHOTOGRAPHY RELEASE FORM

For your consideration, I, the undersigned, hereby give V Boutique and its clients or agents permission for the use of the photographs they have taken of me.

1. To copyright the same in their name or any other name that they may choose.
2. To use and publish the same in whole or in part, individually or in conjunction with other photographs, in any medium for any purpose, including art, illustration, promotion, advertising or trade.
3. It is understood that the use of the photographs is for illustrating a medical procedure and demonstration of treatment outcomes. It is also understood that the use of the photographs will in no way reveal patient identity.

I hereby release V Boutique and its agents from any and all claims and demands arising out of, or in conjunction with, the use of these photographs.

I am of legal age. I have read the foregoing fully and understand its contents.

_____ _____

Print Name Date

_____ _____

Patient Signature Date