Chucktown
Cosmetic Dental and Facial Aesthetics

Name: _____ DOB:_____

Address: _____

City: _____ State: ____Zip: _____ Phone Number: _____

Email Address: _____would you like to receive emails? ____

Occupation: _____ Emergency Name and Contact: _____

How did you hear about us? _____

Chucktown Cosmetic Dental and Facial Aesthetics are committed to providing you with the highest quality care. To insure your safety and well- being, please answer the following questions about your current health and medical history.

Current History

Have you recently been or are you currently sick (cold, flu, etc.)? NO YES

Are you currently feeling pain or tension? NO YES

If yes, please describe: _____

Do you have allergies or sensitivity to:

Oils	Aspirin	Scents
Fish/Shellfish	Lotions	Lavender
Honey	Chamomile	Coconut Oil
Lactic Acid	Citrus Fruit	Salicylic Acid

If yes, please explain: _____

Are you pregnant? NO YES If yes, how many weeks? _____

Do you wear contact Lenses? NO YES

Your eyes will be closed during most of the session, and depending on the type of treatment, a cool compress may be applied to your eyes.

Are you currently under a doctor's care? NO YES

If yes, for what? _____

Skincare History

Have you seen a doctor in the past year for a skin disorder? NO YES

If yes, Please explain: _____

Do you have rosacea? NO YES

Which of the following terms would you use to describe your skin?

Normal/non-reactive Sensitive Very Sensitive

Have you ever reacted unfavorably to any skin product? NO YES

If yes, please explain: _____

Have you undergone any facial cosmetic surgery, chemical peel, or microdermabrasion in the last 6 months?

NO YES if yes, Please describe: _____

Have you ever had any of the following inject able or fillers in the last 30 days?

Botox or Dysport When? _____ Where on face? _____

Juvederm When? _____ Where on face? _____

Collagen When? _____ Where on face? _____

Radiesse When? _____ Where on face? _____

Restylane When? _____ Where on face? _____

Sculptura When? _____ Where on face? _____

Do you get regular facials, or facial massages? NO YES If yes, how often? _____

What do you hope today's treatment will do for you? _____

Chucktown Cosmetic Dental and Facial Aesthetics Polices

Confidentiality: Our goal is to create a calming and welcoming environment and to provide superb facial therapy experience. All discussion between client and practitioner will remain confidential.

Late Arrivals: If you are late and another client is scheduled with your practitioner after your service your session will end at the time it was scheduled to end.

Cancellations: Please remember that your appointment time is reserved for you. If you do not arrive, everyone misses out: you, another client who could have taken that spot, and the technician. If your do not show up for your appointment or cancel with less than 24 hours notice, unless due to sudden illness or emergency, payment for the session is due in full.

Consent for Treatment: I have read the above polices and agree to abide by them. I understand there are conditions for which treatment is not appropriate (contraindicated). I have given a complete health history, and acknowledge that all the information on this form is accurate. By signing this release, I hereby waive and release Chucktown Dental and Facial Aesthetics from all liability. I give my consent to receive treatment.

_____ _____

Signature Date