PANHANDLE PLASTIC SURGERY
ESTHETICIAN INTAKE FORM
ALL INFOMATION IS CONFIDENTIAL

Today's Date: _____

Name: _____ Birthday: _____

Address: _____Email: _____

City: _____ State: _____ Zip: _____

Home #: _____ Cell #: _____ Occupation:_____

Marital Status: ___ Male: ___ Female: ___ Emergency Contact: _____#:_____

Patient Race:_____ Ethnicity: Hispanic____ Non-Hispanic ____Declined to Specify____

MEDICAL HISTORY

Check Box Where Applicable/Fill in With Details:

{) Acutane ( ) Acne ( ) Allergies: _____

( ) Arthritis ( ) Depression ( ) Any Metals in Body: _____

( ) Epilepsy ( ) Diabetic ( ) Heart Condition: _____ Pacemaker: ____

( ) Fever Blisters ( ) Eczema ( ) Blood Pressure ( ) High ( ) Low

( ) HIV ( ) Hepatitis ( ) Hyper / Hypo Pigmentation

( ) Lupus ( ) Insomnia ( ) Hyper / Hypo Thyroid

( ) Plastic Surgery ( ) Pregnant ( ) Planning on getting Pregnant

( ) Psoriasis ( ) Retin-A ( ) Skin Cancer – Where: _____

( ) Seborrhea ( ) Rashes ( ) Shingles ( ) Bleeding Disorders

( ) Warts ( ) Surgeries: _____

( ) Medications: _____

PERSONAL SKIN CARE HISTORY

Check Current Products You Use:

( ) Eye Cream ( ) Cleansing Cream ( ) Facial Soap

( ) Day Cream ( ) Night Cream ( ) Eye Cream ( ) Skin Toner / Astringent

( ) Mask ( ) Facial Scrub ( ) Exfoliants ( ) Neck Cream

( ) Body Lotion ( ) Body Scrub ( ) Hand Cream ( ) Exfoliating Body Soap

PERSONAL EVALUATION QUESTIONNAIRE

Please Reply in Detail To the Following Questions:

1. How did you hear about us? _____
2. What is your major reason for being here today? _____

_____

(Continued)

3. What skin type and/ or problem do you feel you have? _____

_____

_____

4: Have you ever had a facial treatment before? If yes, where and when? Was it a beneficial experience?

_____

_____

5. Have you ever had a reaction to a food, cosmetic, or skin care product? If yes, please give details.

_____

_____

_____

6. Where do you purchase most of your face and body care products? _____

_____

7. How much time do you spend on your daily skin care/ make-up routine? _____

_____

8. How do you feel about your skin conditions? What would you like to improve? _____

_____

_____

9. Do you tend to tan or burn? _____
10. Do you smoke? Yes: _____ No: _____ How Often? _____
11. Do you drink? Yes: _____ No: _____ How Often? _____
12. Do you exercise? Yes: _____ No: _____ How Often? _____
13. How much sleep do you get per night? _____
14. Are you interested in long or short term treatment? _____
15. Are you pleased with your current products? _____
16. Have you ever been waxed? _____

I understand and agree to comply with all the treatment policies listed below:

1. We do not wax anyone on Accutane, Retin-A, or other medications /products that exfoliate or thin the skin. We do not wax anyone undergoing chemotherapy or radiation treatments.
2. We will not treat clients with questionable medical conditions such as Herpes Simplex (cold sores, fever blisters), open wounds or sores, healing incisions, infectious diseases, etc.
3. **We require a minimum of 24 hours advance cancellation notice.**
4. I understand that services received here are not a substitute for MEDICAL CARE and any information provided the technician is for educational purposes only.
4. All information received by P.P.S on this chart, is completely private and confidential.
5. Defective products must be returned within ten (10) days of purchase to receive credit
6. Gift certificates are not-refundable and must be **used with a year from date purchased.**

Name: _____ Date: _____

PANHANDLE PLASTIC SURGERY

1301 S Coulter Ste 201
Amarillo, TX 79106

MEDICAL SPA RELEASE OF LIABILITY AND WAIVER

NAME: _____

CELL: _____ HOME: _____

HOME ADDRESS: _____ ZIP: _____

EMAIL: _____ DOB: ___/___/___

EMERGENCY CONTACT: _____ PHONE: _____

By signing this Medical SPA Release of Liability and Wavier, I am confirming that I recognize that there may be inherent risks associated with using certain equipment, utilizing the Medical Spa facilities, participating in programs and/or receiving Spa treatments.

I acknowledge and agree that I am responsible for my own health; that the Medical Spa associates and/or technicians are not health care practitioners and cannot be expected to diagnose and/or treat individual health problems.

I understand that I am responsible for discussing any questions that I may have concerning my health conditions (if any) throughout any program or treatment at the Medical Spa and, should health-related symptoms occur, I will cease my participation and inform Medical Spa personnel of the symptoms.

Consequently, in light of the foregoing, I hereby release the Medical Spa (and its parent corporation(s) and employees and waive any and all claims, liabilities, or damage for personal injuries that I may experience directly or indirectly from receiving Medical Spa related treatments, utilizing the Medical Spa facilities and/or participating in the programs or activities offered by the Medical Spa. Medical facility is overseen by Dr. Elise May.

_____ _____

GUEST SIGNATURE: DATE:

Any Medical Spa guest under 18 years of age must have a parent or legal guardian sign the below acknowledgment pertaining to the release of liability and waiver.

_____

NAME OF MINOR

_____ _____

PARENT/GUARDIAN SIGNATURE DATE:

PANHANDLE PLASTIC SURGERY
COVID-19 RISK INFORMED CONSENT

I _____understand that I am opting for an elective treatment/procedure/surgery that is not urgent and may not be medically necessary.

I also understand that the novel coronavirus, COVID-19, has been declared a worldwide pandemic by the World Health Organization. I further understand that COVID-19 is extremely contagious and is believed to spread by person-to-person contact: and, as a result, federal and state health agencies recommend social distancing. I recognize that Dr Elise May and all the staff at Panhandle Plastic Surgery and the performing facility are closely monitoring this situation and have put in place reasonable preventative measures aimed to reduce the spread of COVID-19. However, given the nature of the virus, I understand there is an inherent risk of becoming infected with COVID-19 by virtue of proceeding with this elective treatment/procedure/surgery. I hereby acknowledge and assume the risk of becoming infected with COVID-19 through this elective treatment/procedure/surgery, and I give my express permission for Dr Elise May and all the staff at Panhandle Practice Surgery and the performing facility to proceed with the same.

I understand that, even if I have been tested for COVID-19 and received a negative test result, the tests in some cases may fail to detect the virus or I may have contracted COVID-19 after the test. I understand that, if I have a COVID-19 infection, and even if I do not have any symptoms for the same, proceeding with this elective treatment/procedure/surgery can lead to a higher chance of complication and death.

I understand that possible exposure to COVID-19 before/during/after my treatment/procedure/surgery may result in the following: a positive COVID-19 diagnosis, extended quarantine/self-isolation, additional tests, hospitalization that may require medical therapy, Intensive Care treatment, possible need for intubation/ventilator support, short-term or long-term intubation, other potential complications, and the risk of death. In addition, after my elective treatment/procedure/surgery, I may need additional care that may require me to go to an emergency room or a hospital.

I understand that COVID-19 may cause additional risks, some or many of which may not currently be known at this time, in addition to the risks described herein, as well as those risks for the treatment/procedure/surgery itself.

I have been given the option to defer my treatment/procedure/surgery to a later date. However, I understand all the potential risks, including but not limited to the potential short-term complications related to COVID-19, and I would like to proceed with my desired treatment/procedure/surgery.

Patient Initials _____

INFORMED CONSENT FOR COVID-19 RISK

I UNDERSTAND THE EXPLANATION AND HAVE NO MORE QUESTIONS AND CONSENT TO THE TREATMENT/PROCEDURE/SURGERY.

NAME: _____ **DATE:** _____

WITNESS: _____ **DATE:** _____

I have been offered a copy of this consent form: **Patient Initials** _____