PRECISION
AESTHETICS

949-477-9740
1805 E. DYER RD, #110., SANTA ANA, CA 92705

Patient Registration Form

Name_____Date____/____/____

Email _____ ☐ I want to receive promotions and email communications

Address _____
City State Zip

Occupation_____

Phone _____ Cell Home Office

DOB____/____/_____Age_____How did you hear about us? _____

Marital Status (please circle): Single Married Divorced Widowed

Sex (please circle): Female Male

Emergency Contact_____Phone _____

Interests/Concerns:

□ Botox □ Kybella (Double Chin)
□ Skincare Products/Peels (Skin Pigmentation, Fine lines, Skin Texture)
□ Fillers □ Laser Treatments (Skin Pigmentation, Wrinkles, Skin Texture)
□ Latisse (lengthen, fill in lashes)
□ Microneedling (fine lines, wrinkles, acne scars, tightening)

Have you ever had any of the following in the past? (please circle)
Botox Fillers Latisse Laser Treatments

If so, when was your last treatment? _____

Do you have skin care products that you prefer? Please list: _____

Any likes or dislikes about past treatments? _____

Are you happy with your skin? Y N If not, please explain _____

_____

Medical History/Good Faith

Are you currently taking any medications, vitamins or supplements? If so, please list _____

_____

_____

Do you have any allergies to medication? If so, please list _____

Have you been on Isotretnoin(Accutane) in the last 6 months? Y N

Are you pregnant or nursing? Y N

Do you take any blood thinners (ex: Aspirin, Coumadin)? Y N

Do you have any medical problems or illnesses? If so, please explain _____

_____

Do you smoke? Y N Do you drink alcohol? Y N Do you get fever blisters? Y N

Are you currently under the care of a Dermatologist? Y N Do you have facial implants? Y N

Do you have a history of scarring easily? Y N

Any allergy or sensitivity to:

□ Lidocaine □ Benzocaine □ Tetracaine

□ Latex □ Food Allergies □ Skin Allergies

Do you have a history of the following?

Any disease that affects the muscles and nerves? □Yes □No

Amyotrophic Lateral Sclerosis (ALS)? □Yes □No

Myasthenia Gravis? □Yes □No

Eaton Lambert Disorder? □Yes □No

Bells Palsy □Yes □No

Drooping eyelids □Yes □No

_____ ____/____/_____

Patient Signature Date

(Office use only)

Patient Cleared for the Following:

Injectable Procedures	Laser Procedures	RX Products
□ Botox	□ Laser Genesis	□ Latisse
□ Juvederm/Voluma/Volbella/vollure	□ Laser Hair Removal	
□ Belotero	□ Laser Vein Therapy	
□ Radiesse	□ Pearl Fractional	
□ Microneedling		
□ Kybella		

_____ _____ ____/____/____

R.N. Name R.N Signature Date

_____ _____ ____/____/____

M.D./P.A. Name M.D./P.A Signature Date