GREENVILLE HEALTH SYSTEM

Please Print

Today's Date _____ Date of Birth _____

Name (First, Middle, Last) _____

Address (Street, City, State, Zip) _____

_____

Home Phone ( ) _____ Work Phone ( ) _____

Mobile ( ) _____ E-Mail _____

Race _____ Please Circle: Male Female

Spouse / Emergency Contact Information

Name (First, Middle, Last) _____

Relationship _____ Home Phone ( ) _____

Work Phone ( ) _____ Mobile Phone ( ) _____

How did you hear about us? Friend Walk-in Gift Certificate Internet/ Website

Physician (Who) _____ Ad (Where) _____ Other _____

The following information is necessary to evaluate and meet your individual needs. All information is confidential.

Are you interested in:

Products Services Laser Hair Reduction Botox Dermal Filler

Pigmentation (brown spots or patches) Rosacea or Vascular (broken capillaries)

Surgical or Acne Scarring Acne Treatment Treating Fine Lines & Wrinkles

What two specific changes would you like to see with your skin? _____

_____

Have you ever had any of the following?

Cosmetic / Reconstructive Surgery	Yes	No	Laser resurfacing	Yes	No
Laser hair removal	Yes	No	Chemical Peels	Yes	No
Botox	Yes	No	Pace maker	Yes	No
Filler (Restylane Juvederm, Sculptra)	Yes	No	Implants (Chin Cheek)	Yes	No
Metal Prosthetics (Knee plates, etc.)	Yes	No			

Circle any health conditions you have had or are now experiencing.

Allergies	Hepititis	Pregnancy	Thyroid Problems
Cancer	HIV or AIDS	Rosacea	Other _____
Diabetes	Hormonal	Skin Disease	_____

List all supplements and medications that you take regularly, including hormones, vitamins, etc.

_____

_____

_____

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List all topical prescription / nonprescription products you are using on your skin including skincare products and makeup. _____

_____

_____

_____

List any allergies including nuts, seafood, coconut, aspirin, sulphur, etc. _____

_____

Do you have a history of cold sores or fever blisters? Yes No Where? _____

Do you smoke? Yes No

Are you a GHS Employee? Yes No Are you interested in Payroll Deduction? Yes No

Method of Payment: Payment is due at time of service. You may pay your bill with cash, personal check, certain credit cards, or debit card. Product returns accepted if paid for by credit or debit card only. Products purchased with cash or check may only be returned for store credit (gift card). No returns on product that has been opened.

Returned Checks: A $25.00 service charge will be added on all checks returned to us for insufficient funds.

No-show Appointments: There is a $25 charge for missed appointments that are not cancelled within 24 hours of the appointment time.

Consent: I consent to facial treatments performed by the aesthetician. Treatment may include, but is not limited to, the application of various skin care products for the purposes of cleansing, toning, exfoliating or moisturizing the skin. If other treatments are recommended that require more specialized applications or procedures, a separate information and consent form will be offered prior to treatment.

Contacting Clients: I hereby authorize GHS to contact me through the information provided at the time of registration.

Photographing: I consent to GHS taking photographs for purposes of identification, diagnosis, treatment, education & research. Photographs that could identify me will only be used for medical record identification purposes unless I specifically agree and sign an additional consent.

Notice of Privacy Practices: I authorize GHS to provide any health information related to me to the insurance company or other payor, for purposes of payment for the health care provided. I also authorize GHS to provide health information to other physicians and healthcare facilities for continuing care. I further agree that GHS can use the health information for operations such as peer review and outcomes analysis. I acknowledge by signing below that I have received a copy of the GHS Notice of Privacy Practices.

Patient/Guardian_____ Date _____ Time _____

Witness_____ Date _____ Time _____