AGELESS AESTHETICS

5375 SOUTH FORT APACHE SUITE 101
LAS VEGAS, NV 89148
PHONE: (702) AGE-LESS (243-5377)

Patient Information

Last Name:_____ First Name:_____

Address:_____

City:_____State:_____Zip:_____

DOB:_____/_____/_____ Age:_____ Telephone: (____)_____

Occupation: _____ Employer: _____

Work Phone: (____)_____ E-Mail Address:_____

Emergency Contact Name:_____ Telephone: (____)_____

Address:_____

Medical Questions

What are you being seen for?

☐ Consultation ☐ VelaShape ☐ Botox ☐ Filler ☐ Glycolic Peel ☐ Chemical Peel ☐ Laser

☐ Other:_____

Which conditions would you like to improve? (Please check all that apply)

☐ Sun Damage ☐ Acne Scarring ☐ Stretch Marks ☐ Dark Circles Under Eyes

☐ Age Spots ☐ Enlarged Pores ☐ Under Eye Bags ☐ Inch Loss ☐ Cellulite Reduction

☐ Hyperpigmentation ☐ Contouring of Neck, Jaw, Cheeks ☐ Loss of Collagen & Elastin

☐ Other:_____

Patient History

Do you bruise easily? Yes / No
Do you wear contact lenses? Yes / No
Do you suffer from water retention? Yes / No
Do you suffer from a capillary condition? Yes / No
Do you have any hormone imbalance? Yes / No
Do you follow an exercise routine? Yes / No
Do you suffer from sensitive migraines? Yes / No
Do you smoke? Yes / No
Are you pregnant or trying to get pregnant? Yes / No
Are you epileptic or suffer from seizures? Yes / No

How many glasses of water do you drink a day?_____

How sensitive is your skin? Not at all/ Mild/ Extremely

Do you have any serious illness? Yes / No
Details:_____

Do you have any allergies? Yes / No
Details:_____

Are you taking any medication? Yes / No
Details:_____

Do you have low blood pressure or thyroid issues? Yes / No
Details:_____

Do you take blood thinners? Yes / No
Details:_____

Have you had any recent operations? Yes / No
Details:_____

Do you have or have you ever had any of the following? (Please check all that apply)

☐ Kelloid Scarring ☐ Hepatitis ☐ Dermatitis ☐ Bruising ☐ Acne Scarring
☐ HIV+ ☐ Eczema ☐ Melanoma ☐ Hemophilia ☐ Herpes Simplex
☐ Varicose Veins ☐ Metal Implants ☐ Pace Maker ☐ Diabetes

Patient History Continued

Any Other conditions?

_____

_____

_____

Have you ever had any of the following treatments? (Please check all that apply)

☐ Microdermabrasion ☐ VelaShape ☐ Botox ☐ Filler ☐ Glycolic Peel ☐ Chemical Peel

☐ Laser ☐ Cosmetic Surgery ☐ Liposuction ☐ Tummy Tuck

☐ Other:_____

Do you use or have you used any of the following products?

☐ AHA ☐ Hydroquinone ☐ Retin-A

Payment Agreement

_____ I hereby guarantee payment of all charges incurred by me today.
Initials

I, _____, answered the following questions truthfully and I understand that some conditions may be indications to receiving treatment. The facility will therefore not accept my liability for injury or damages as a result of false information given. Furthermore, I know that it is my responsibility to alert the therapist about any recent surgeries or skin resurfacing procedures. Without the above disclosure, I understand that the technician cannot optimize the effectiveness of the treatments, which are designed to provide clients with superior results. By Signing below, I consent to the procedure.

_____
Print Name

_____ _____
Signature Date

_____ _____
Skin Care Professional Date

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Informed Medical Consent

I authorize Ivan L. Goldsmith, M.D. and his medical staff to perform my elective procedure/procedures including, but not limited to Botox, Dysport, Xeomin, Dermal Fillers, Chemical Peels, and Laser treatments. I have thoroughly researched and understand the nature and purpose of the procedures. I understand the risks and benefits of my desired procedure(s). I further understand that all of these are elective procedures and I may incur side effects including but not limited to bruising, temporary or permanent, drooping or nerve damage, hardening under the skin, scarring, tingling, skin burn or infection.

_____ No warranty or guarantee has been made to me on the outcome of the
Initials procedure(s) or of a definitive cure.

_____ I understand that the explanation I have received is not exhaustive and that more risks
Initials and/or complications may arise. I have been offered a safety information handout specific to my procedure(s). If I desire a more complete explanation of any of the foregoing, such explanations will be given to by Ivan L. Goldsmith, M.D. upon my request.

_____ I am not pregnant or nursing. If I become pregnant, I will inform Ivan L. Goldsmith,
Initials and/or his staff.

_____ I understand that not all patients respond equally and results may vary.
Initials

_____ I hereby consent and authorize Ivan L. Goldsmith, M.D. and/or his staff to perform
Initials any of the above mentioned elective procedure(s).

_____
Print Name

_____ _____
Signature Date

_____ _____
Skin Care Professional Date