Intake Form

Name:____

Address:____

City:________________State:_________Zip:_____________

Home Phone:____

Cell Phone:____

EMAIL:____
Would you like to be added to our email list to receive updates, promotions, and events? ☐ Yes ☐ No

Date of Birth:____

Emergency Contact:___________________________________

Current Medical Conditions:____________________________

____

Current Medications/Vitamins:__________________________

____

Medication Allergies:__________________________________

Pharmacy:____

Are you a member of *Brilliant Distinctions* or *Aspire Rewards*? ☐ Yes ☐ No

How Did You Hear About Us?____________________________

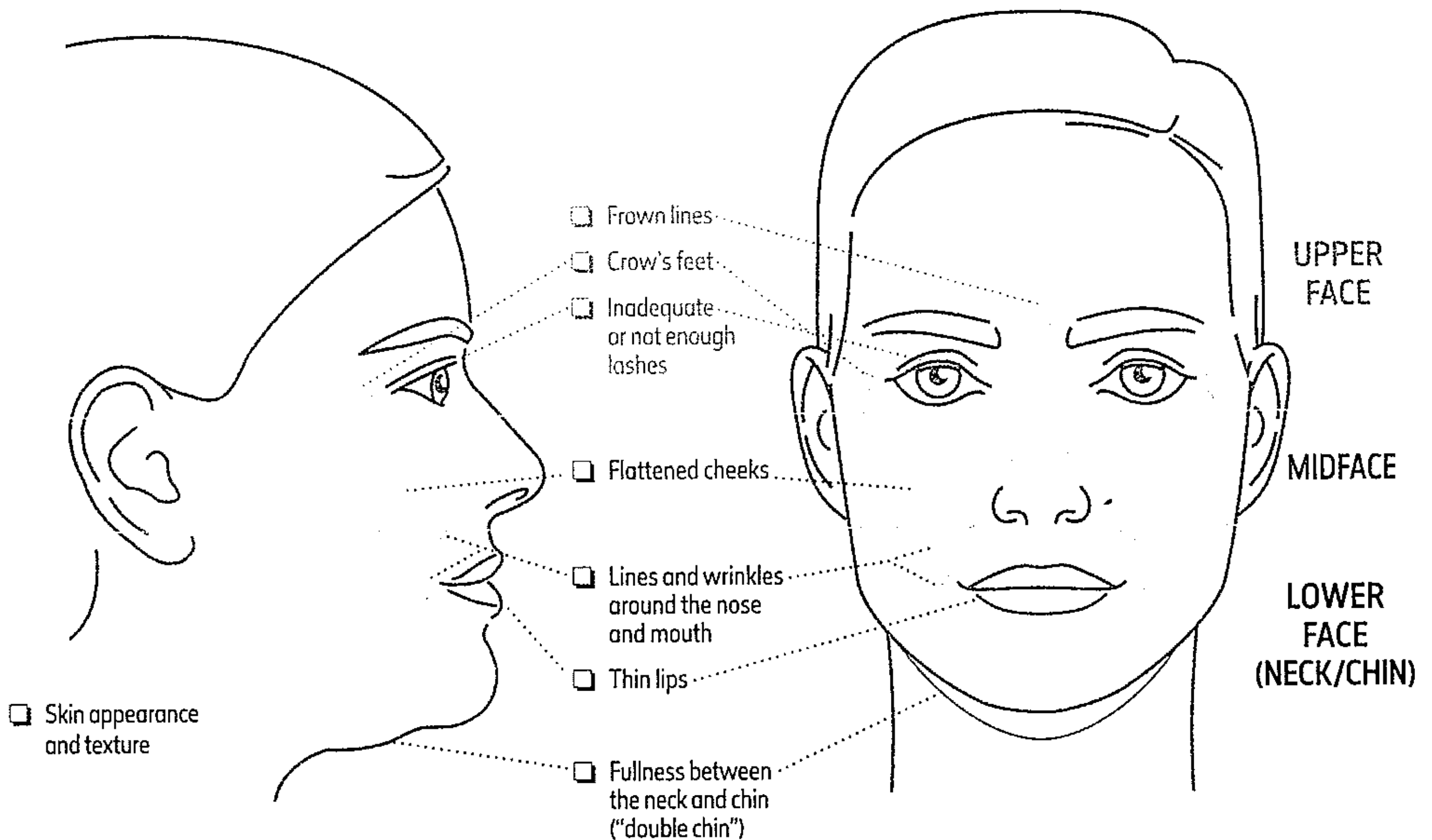
SELF-ASSESSMENT

NAME: ______________________ DATE OF BIRTH: ______________ DATE: ______________

What brings you in today? ______________________________

Select which areas of the face concern you on the diagram below.

By sharing how you see yourself, we can best evaluate your aesthetic goals and select an appropriate treatment for you.



Please complete and return this form to the front office before your consultation.

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