Sutha Sachar MD
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323.602.1332

Registration

Last Name _____ First Name _____Birth Date _____

Cell Phone _____ Email _____ Sex (circle) **M F**

Street Address _____ City _____ Sate _____ Zip _____

Emergency Contact _____ Phone _____ Physician _____

May we email or text you appointment reminders? Y / N May we email or text you with MedSpa promotions? Y / N

How did you hear about Signature Med Spa? [ ] TV [ ] Online [ ] Social Media [ ] Friend/Family_____

Your Health

Do you have any allergies? [ ] No [ ] Yes, List _____

Have you been under the care of a medical professional within the past year? [ ] No [ ] Yes, Reason: _____

List medications and/or supplements taken regularly: _____

Any recent surgery, including plastic surgery? [ ] No [ ] Yes, Dates: _____

Any skin cancer? [ ] No [ ] Yes, Explain: _____

Any piercings, tattoos, or permanent cosmetics? [ ] No [ ] Yes, Explain: _____

Do you smoke? [ ] No [ ] Yes, Frequency: _____

Are you interested in our weight loss program? [ ] Yes [ ] No

Are you interested in testing your horomones? [ ] Yes [ ] No

Do you use any Retinol/Vitamin A, Adapalene, Deferin, AHA, Glycolic Hydroxyl, Salicylic Acid? Have you used any of the above products in the last 3 months?[ ] Yes [ ] No If so, which? _____

Have you used acne medication? [ ] No [ ] Yes, Which: _____

Ethnic background: _____

Do you have hyperpigmentation or hypopigmentation or marks after physical trauma? Describe: _____

Do you form thick or raised scars from cuts or burn? [ ] No [ ] Yes, Describe: _____

Have you been exposed to the sun or used a tanning bed in the last 48 hours? [ ] No [ ] Yes, Describe: _____

How frequently are you exposed to the sun or use a tanning bed? _____

Do you have any metal implants or a pacemaker? [ ] No [ ] Yes, Describe: _____

Have you had an adverse reaction to a skincare product? [ ] Rash [ ] Irritation [ ] Peeling [ ] Sun Sensitivity [ ] Breakout

Female Clients Only:

Are you taking oral contraceptives? [ ] No [ ] Yes, specify: _____

Any recent changes to or from your contraceptive treatment? [ ] No [ ] Yes, specify: _____

Are you experiencing any menopause problems? [ ] No [ ] Yes, specify: _____

Are you pregnant or trying to become pregnant? [ ] Yes [ ] No

Are you lactating? [ ] Yes [ ] No

Your Health

Have you ever had any of the following health conditions in the past or present?

Cancer	Yes [ ] No [ ]	Arthritis	Yes [ ] No [ ]	HIV/AIDS	Yes [ ] No [ ]
Hormone Imbalance	Yes [ ] No [ ]	Asthma	Yes [ ] No [ ]	Lupus	Yes [ ] No [ ]
Systemic Disease	Yes [ ] No [ ]	Eczema	Yes [ ] No [ ]	Metal bone pins/plates	Yes [ ] No [ ]
High Blood Pressure	Yes [ ] No [ ]	Skin Disease/Lesions	Yes [ ] No [ ]	Phlebitis or poor circulation	Yes [ ] No [ ]
Spinal Injury	Yes [ ] No [ ]	Any Active Infection	Yes [ ] No [ ]	Blood clotting abnormalities	Yes [ ] No [ ]
Thyroid Condition	Yes [ ] No [ ]	Headaches (chronic)	Yes [ ] No [ ]	Psychological Treatment	Yes [ ] No [ ]
Hysterectomy	Yes [ ] No [ ]	Hepatitis	Yes [ ] No [ ]	Insomnia	Yes [ ] No [ ]
Diabetes	Yes [ ] No [ ]	Herpes	Yes [ ] No [ ]	Keloid or Hypertrophic Scar	Yes [ ] No [ ]
Heart Problem	Yes [ ] No [ ]	Frequent Cold Sores	Yes [ ] No [ ]	Seizure Disorder	Yes [ ] No [ ]
Varicose Veins	Yes [ ] No [ ]	Immune Disorders	Yes [ ] No [ ]	Fever Blisters	Yes [ ] No [ ]
Chronic Skin Condition	Yes [ ] No [ ]	Photosensitivity	Yes [ ] No [ ]	Pigmentation Disorder	Yes [ ] No [ ]

MedSpa Questions- Have you ever had: (Please check all that apply)

Recent Waxing or Plucking	Yes [ ] No [ ]	Botox Injection	Yes [ ] No [ ]	Recent Sunburn or Tan	Yes [ ] No [ ]
Laser Skin Resurfacing	Yes [ ] No [ ]	Dermal Filler Injection	Yes [ ] No [ ]	Used Accutane	Yes [ ] No [ ]
Electrolysis or Threading	Yes [ ] No [ ]	Chemical Peel	Yes [ ] No [ ]	Used Tetracycline	Yes [ ] No [ ]

Photo Consent

I grant permission to Sutha Sachar MD for the use of the photographs and images in any presentation including social media, office use and other marketing materials. I understand that I may revoke this authorization anytime by notifying Sutha Sachar MD. The revocation will not affect any actions taken before the receipt of this written notification. Images will be stored in a secure location and only authorized staff will have access to them.

Patient Signature: _____ Date: _____

Agreement

I understand, have read, and completed this questionnaire truthfully. I agree that this constitutes full disclosure, and that it supersedes any previous or written disclosures. I understand that withholding information or providing misinformation may result in contraindications and/or irritation to the skin from treatments received. I am aware that it is my responsibility to inform the esthetician/skin care therapist of my current medical or health conditions and to update this history. The treatments I receive here are voluntary and I release this institution and/or skin care professional from liability and assume full responsibility thereof.

I also understand that all payments are non-refundable, non-transferable, and must be used within six months.

By signing below I am agreeing to the terms outlined above.

Patient Signature: _____ Date: _____

Signature Med Spa

by SU SACHAR MD

Med Spa Policies

Late Policy

We ask that clients please arrive 10-15 minutes early so that we may start your service on time. A late arrival may reduce your appointment time out of respect to the clients scheduled after you. We will make every effort to accommodate your full appointment, but this is not always possible based on our schedule. If we are the cause of your lateness, your appointment time will not be affected.

Missed or Cancelled Appointments

Please understand that when you forget or cancel your appointment without giving enough notice, we miss the opportunity to fill that appointment time for clients on our waiting list.

- Please give notification at least 24 hours prior to your appointment.
- Notification given less than 24 hour prior to appointment time will result in a credit card requirement for our files. This card will be charged a fee of $25 for any future appointments that are cancelled less than 24 hours prior to the appointment time.

By signing below I understand and agree to the terms outlined above.

Name: _____

Signature: _____

Date: _____