

FIBROBLAST Medical Intake Form

PLEASE READ CAREFULLY AND SIGN WHERE INDICATED, Only, when you are ready to proceed and have discussed all points with specialist, your service will then begin. You are signing you fully understand and accept the terms of Treatment your having today. What to Avoid and how to care during healing period will be fully explained. Plus, Aftercare products with fully written instructions will be given to you today before leaving.

Valid ID Info (DL) _____ Age _____

Today's Date: ___/___/___ Birth date: ___/___/___ Cell Phone _____

Name: _____ Email: _____

Home Address: _____
No. & Street City State Zip

Work Address: _____
No. & Street City State Zip

Home Phone: (____) _____ Work Phone: (____) _____

Employer: _____ Occupation: _____

Are you now or have you been under the care of a physician within the last two years? _____

If yes, please provide Physician's Name, address and phone number _____

Person to contact in an emergency: _____
Name _____
Address & Phone No. _____

List all medications you are currently taking, including Retin A, Glycolic Acid and Acutane: _____

List any drug, makeup, skin or food ALLERGIES (i.e., soaps or cleansing creams):

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Do you feel fit and well to have Fibroblast Plasma Treatment today? _____

Fibroblast is an art process - not an exact science and I / Donna or Velvet Touch Permanent Cosmetics & Skin Care, LLC cannot guarantee, and exact shrinkage result due to skin elasticity and individual healing.

I, _____ you have chosen Fibroblast Plasma cosmetic procedure that is no medically necessary:

Sign: _____ Date _____