*Medically yours,*

**Stacy L. Davidson, FNP- BC**

*innovative health and skincare for all*

**COSMETIC REGISTRATION & CLIENT QUESTIONNAIRE**

**Contact & Background Information:**

**Today's Date:** ______________________ **Primary Care Provider:**________________________________________

First Name: ____________________________Middle:___________________ Last Name: _______________________________

Is this your legal name? ❑ Yes ❑ No If not, what is your legal name?_____________________________________________

Birthdate: ________________ Age:________ Sex: Male ❑ Female ❑

Home Address: _________________________________________ City: _____________________State: ______ Zip: _________

Home #: _____________________ Mobile #: __________________________ Work #: _________________________________

E-mail Address: ___________________________________________May we send confirmations to email address? ❑ Yes ❑ No

If not, what number shall we contact you and at what times? ________________________________________________________

Are you single, married, divorced or widowed? ________________ How did you learn about us? ___________________________

**Emergency Contact Information:**

Emergency Contact Name: ________________________________ Emergency Contact Phone #:___________________________

What is their relationship to you? ________________________________

**Cosmetic Procedure Goals:** Indicate the cosmetic procedure(s) you are considering:

Medically Aesthetic**:** ❑ Facials ❑ Chemical Skin Peel ❑ Microdermabrasion/Dermaplaning ❑ Eyelashes ❑ Waxing

Non-Surgical Facial Rejuvenation: ❑Botox ❑Dermal Filler ❑Laser ❑Led ❑IPL ❑Vampire Facial/Vampire Facelift

Area(s) ❑Cheeks ❑ Chin ❑ Lips ❑ Eyelids ❑Neck ❑ Hands ❑ Arms ❑Other

What is the primary reason for this consultation? ________________________________________________________________

What specific features of yourself do you dislike? Why?

____________________________________________________________________________________________________________

How long have you been considering a cosmetic procedure? Is this motivated by an event?

____________________________________________________________________________________________________________

Is the cosmetic procedure your idea, or is someone else urging you to have it?

____________________________________________________________________________________________________________

Do you understand that the object of any cosmetic procedure is improvement in appearance, not perfection? ❑ Yes ❑ No

Do you realize that every procedure is followed by a period of healing before tissues return to normal and the final result is apparent?

❑Yes ❑ No

Why did you select us for a consultation visit? ____________________________________________________________________

**Cosmetic Procedure History:**

Have you consulted any other physician about a cosmetic procedure? ❑ Yes ❑ No

If yes, when? ______________________________________________________________________________________________

Please tell us about any previous cosmetic procedures or cosmetic surgeries you've had:

____________________________________________________________________________________________________________

Were you satisfied with the results? ❑ Yes ❑ No Were you satisfied with the providers(s)? ❑ Yes ❑ No

If not, why were you unsatisfied? _____________________________________________________________________________

**I acknowledge that the above is complete and accurate. I am at least 18 years of age or, if not, I am accompanied by a legal guardian. I hereby consent to and authorize Stacy L. Davidson, FNP-BC to evaluate, plan, and help educate me on the possibilities of procedures I can be offered. I understand that photos are helpful and I authorize the taking of photos, which will be used solely for documentation and be kept confidential. I agree that any critical omission or misrepresentation may lead to change in pricing or cancellation.**

***Please review the above information for accuracy, which you hereby verify by signing below.***

**Signature:** ____________________________________________ **Date:** _____________

**Relationship to client: ❑Self ❑Spouse ❑Parent ❑Guardian**

**A cosmetic consult for a new patient is 15 minutes at no charge.**

**If the consult or cosmetic service requires extensive questions/education, prescriptions and /or referrals a $50.00 fee will be charged for an office visit. During your cosmetic visit, if no product is injected and an appointment is scheduled the same day as the office visit a fee of $50.00 will be waived. Payment is due at the time of service.**