



CALIFORNIA FACE INSTITUTE

DERMAL FILLERS INTAKE

DATE

[Blank input field for name]

DATE OF BIRTH AGE PHONE EMAIL

[Blank input field for date of birth] [Blank input field for age] [Blank input field for phone with phone icon] [Blank input field for email]

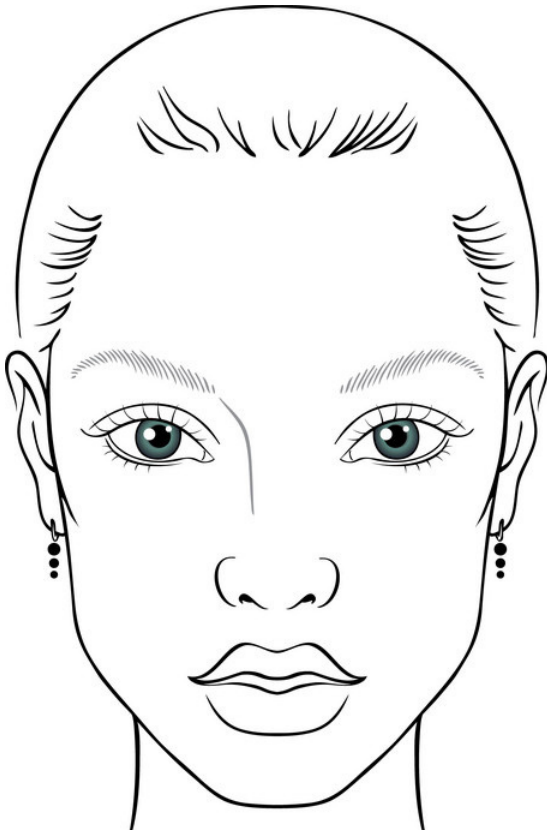
ADDRESS CITY STATE

[Blank input field for address] [Blank input field for city] [Blank input field for state]

AHC FOR MEDICAL BOTOX EMERGENCY CONTACT (*Name / Relationship / Phone)

[Blank input field for AHC for medical botox] [Blank input field for emergency contact]

YOUR CONCERNS | WHAT AREAS WOULD YOU LIKE TREATED?



[Large blank area for writing concerns and treatment preferences]

PAST COSMETIC TREATMENT HISTORY

- | YES | NO | |
|--------------------------|--------------------------|--------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Botox |
| <input type="checkbox"/> | <input type="checkbox"/> | Facial surgery |
| <input type="checkbox"/> | <input type="checkbox"/> | Permanent implants in the face |
| <input type="checkbox"/> | <input type="checkbox"/> | Permanent fillers |
| <input type="checkbox"/> | <input type="checkbox"/> | Juvederm products |
| <input type="checkbox"/> | <input type="checkbox"/> | Skin tightening |
| <input type="checkbox"/> | <input type="checkbox"/> | Are you pregnant or nursing? |

[Blank box] Please Initial



CALIFORNIA FACE INSTITUTE

DERMAL FILLERS MEDICAL

DATE

[Empty rectangular box for patient information]

[Empty rectangular box for date]

ALLERGIES

PLEASE LIST ALL OF YOUR ALLERGIES

[Large empty rectangular box for listing allergies]

MEDICATIONS

PLEASE LIST ALL OF YOUR CURRENT PRESCRIPTION, OTC, HERBAL PRODUCTS THAT YOU ARE TAKING.

[Large empty rectangular box for listing medications]

PAST MEDICAL HISTORY

PLEASE LIST ALL OF YOUR CURRENT MEDICAL CONDITIONS.

[Large empty rectangular box for listing past medical history]

