Renaissance Medical Spa

Date _____ Home Phone_____ Cell Phone_____

Last Name: _____First Name: _____Nick Name:_____

Address _____City, State, Zip_____

Sex: ❑ Male ❑ F emale Birthdate: ____/____/____ ❑ Single ❑ Married ❑ Widowed ❑ Separated ❑ Divorced

Anniversary: ____/____/___ SS# (last 4 digits) _____ Referred by: _____

Employer: _____ Work Phone: _____

Preferred Language: _____ Race & Ethnic Group: _____

Occupation:_____ If student: ❑ Full-time ❑ Part-time Email: _____
(We email monthly specials, birthday discounts, etc.)

In case of emergency who should be notified?_____ Phone:_____

Do we have permission to:
- Leave a message on your answering machine: ❑ Yes ❑ No
- Leave a message at your place of employment? ❑ Yes ❑ No
- Discuss your medical condition with any member of your household? ❑ Yes ❑ No

May we discuss information regarding your services with any memeber of your household? ❑ Yes ❑ No

If yes, whom:_____ Relationship:_____

Are you using any of the following products?

❑ Renova ❑ Glycolic Acid ❑ Benzoyl Peroxide ❑ Accutane ❑ Retin-A

Do you wear contact lenses? ❑ Yes ❑ No
Do you wear dentures? ❑ Yes ❑ No
Do you exercise regularly? ❑ Yes ❑ No
How much water do you drink per day? _____ glasses
Have you ever received a massage before? ❑ Yes ❑ No
Have you ever received a facial before? ❑ Yes ❑ No
Have you ever received a manicure/pedicure before? ❑ Yes ❑ No

Please take a moment to carefully read the information you have provided to be sure it is as accurate as possible. If you have a specific medical condition or specific symptoms, certain treatments may be contraindicated. Please discuss any questions with your service provider prior to service.

_____ _____ Circle One: Self Parent Guardian
Signature of Patient or Legal Guardian Date

_____
Print Name

GUARDIAN OR ADULT SIGNATURE IS REQUIRED IF PATIENT IS UNDER 18