SPA Skin Care Form

Name: **Date:**

Billing Address:

City:	**State:**	**Zip:**

Cell Phone:	**Home Phone:**	**Work Phone:**

E-Mail Address:

Age: **DOB:**	**Ethnicity:** **Race:**

How did you hear about us? (Circle one) Radio Facebook Website Friend: _____

Primary Skin Care Problems? (Check all that apply)

❒ Acne/ Face/ Body	❒ Sagging Skin	❒ Dryness
❒ Elasticity Loss	❒ Growths on Body	❒ Dehydration
❒ Aging Skin	❒ Fine lines/Wrinkles	❒ Skin Sensitivity
❒ Skin Discoloration	❒ Unusual Facial Growths	❒ Hand Spots
❒ Facial Scars	❒ Loss of Pigmentation	❒ Facial Hair
❒ Facial Lines	❒ Unwanted Body Hair	❒ Scarring
❒ Loss of Lip Line	❒ Stretch Marks	❒ Light Facial Hair
❒ Facial Disfigurement	❒ Razor Bumps	❒ Enlarged Pores
❒ Blotchiness/Vessels	❒ Textural Irregularities	❒ Rosacea
❒	❒	❒

Have you visited a cosmetic surgeon in the past 12 months?
Yes No If so, why?

Have you visited a clinical skin care provider in the past 12 months?
Yes No If so, why?

Have you visited a Dermatologist in the last 3 years? Yes No Dermatologist's Name?

Treatment?

At home skin care routine?	AM:	PM:

Are you under a Physicians care? Yes No Name: Phone:

Any medical conditions present?			
If so please explain?			
List any medications:			
List any allergies:			
Do you tan?	❒ Yes Weekly/Monthly/Rarely Sunbathe/Tanning Booth	❒ No	
Do you smoke?	❒ Yes How long? How much?	❒ No	
Do you diet?	❒ Yes	❒ No	Name:
Do you wear contacts?	❒ Yes	❒ No	
Do you exercise	❒ Yes How Often?	❒ No	

Are you under Psychological Counseling? Yes No

Have you ever been prescribed Accutane? Yes No Dose?

Do you have a heart condition? Yes No
If yes, What?

Do you have a pacemaker? Yes No

Please Check and circle all that apply

❒ Herpes/cold sores/warts ❒ Vaginal ❒ Oral	❒ Yes, Date: Medication:	❒ No
❒ HIV/AIDS ❒ Hepatitis C	❒ Yes, Date: Medication:	❒ No
❒ TB	❒ Yes, Date: Medication:	❒ No
❒ Other	Please explain:	

CAPSTONE MEDICAL SPA (CMS) FINANCIAL POLICIES

PLEASE REVIEW AND INITIAL

1. Payment is due at check in for ALL services rendered the day of service. Administration does not have control over prices and there are no negotiations.
_____

2. Cancellation is required 24 hours prior to appointment; failure to cancel within the required time will result in a fee of $35. A No Show is considered failure to cancel or failure to show for a scheduled appointment, this will result in a fee of $50. If you need to cancel you may call our main number at 907-357-9590 option 5 and speak with our Spa assistant or leave a message. Another option would be to email spa@capstoneclinic.com. Clients who have prepaid for package deals who are no shows or have late cancellations for their scheduled appointments will automatically be deducted the cancellation fee from the package balance._____

3. As a courtesy to our clients Capstone Medical Spa's automated system sends out reminder calls 24 hours before your scheduled appointment. If this call is not received for any reason CMS is not responsible. It is our clients' responsibility to maintain their appointment. _____

4. Capstone Medical Spa will charge a fee of $30.00 for any checks marked NSF from the bank. It is also the policy of CMS that the client's account be flagged until the debt has been repaid._____

5. We love children and we understand that you may have child care issue(s); however, it not appropriate to bring your child under the age of 12 to your appointment due to the use of some of our equipment and small treatment rooms. Children may not be left unattended under ANY circumstance for liability issues. You will need to reschedule your appointment should your child(ren) under the age of 12 come with you to your spa appointment._____

Signature **Date:**

Practitioner's notes:

Date:

Notes:

Treatment Course Suggested:

Additional Notes

Prescriptions/Products

Predisposition Test