Please take the time to fill out the following information as completely and accurately as possible. If you are uncomfortable answering any of these questions, please leave them blank and you can discuss them with either your doctor or nurse.

Personal Information

First Name: _____ Middle _____ Last Name _____

Please Call Me… _____ Are you familiar with Elysian **Wellness**? ___Yes ___No

Date of Birth: _____/_____/_____ Age: _____ Social Security Number: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Telephone: _____ Mobile: _____

E-Mail: _____ Please Circle: Single / Married / Widowed / Divorced

Medical Information

Who is your family physician: _____ Telephone #: _____

Please list any medical condition(s) which you are treated on a regular basis: _____

_____

What medication(s) are you currently taking: _____

_____

Please list any allergies: _____

Person to Notify in case of Emergency: Name: _____ Relationship: _____

Home Phone: _____ Mobile: _____

What brings you in today? _____

Are there any other services that you might like to discuss? Please circle any or all that may apply.

Permanent Hair Reduction	Scar/Stretch Mark Reduction	Diet Pills/Weight Management
Treatment for Spider Veins	Skin Tightening	Wrinkle Treatment
Hair Removal	Removal of Sun Spots/Age Spots	Mineral Make-Up
Botox Injections	Pore Reduction	Referral to the Wellness Center
Dermal Fillers for Facial Creases	Hormone Therapy	Other Related Skin Care Products

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Were you referred here by someone? ___ Yes ___ No If "Yes", Who? _____

If "No", how did you hear about us? _____

Consent for Treatment:

I hereby grant permission to Elysian Med Spa, its doctor(s), nurse practitioner(s), registered nurse(s) aesthetician(s), or other specialist(s) to examine, administer treatment, and/or perform such general procedures as he/she may deem necessary or appropriate in the diagnosis and/or treatment of my condition. I understand that Elysian Med Spa policies are available on the website, www.elysianky.com, and a printed copy is available to me at any time upon request.

I certify that the information given is true and accurate to the best of my knowledge and will notify the office immediately if any changes occur in my medical history or health status.

Printed Patient Name: _____

Signature: _____ Date: _____

Consent for Photographs:

I hereby authorize and consent to having photographs taken of me and that they may be used as an aid in my treatment, to assist with documenting the progress of my treatment, for use in miscellaneous marketing collateral, or for study reporting purposes and that any photographs taken will remain the property of Elysian Med Spa. I understand that my identity will be kept strictly confidential.

Printed Patient Name: _____

Signature: _____ Date: _____