AESTHETIC CONSULTATION

Last Name	First Name
Address	City ST Zip
Age Date of Birth	Cell Phone Home Phone
Email Address* @ .	* *Listing here constitutes permission to Email Special Offers and Discounts*
Occupation/Business:	

Interested In (please check all that apply):

❑ Facial Wrinkles/ Loose Skin	❑ Face/Body: Scars	❑ Body Sculpting
❑ Lips: Thin or Uneven	❑ Skin: Sun Damage/Brown Spots	❑ Thinning Hair
❑ Cellulite	❑ Skin: Large Pores	❑ Eyelash Growth

How did you hear about us? Please Circle One

Yelp Search	Drive by or walk by
Google Maps	Been here before / Email from Look Younger MD
Google Botox / Juvederm	Friend's Name:

Your Medications_____

Drug Allergies:_____

Current Medical problems:_____

On Anti-Inflammatory Meds? ❑ Yes ❑ No Are you Pregnant? ❑ Yes ❑ No

_____

Patient Signature ***Date***

Comments:

Patients for Cheek treatments: ☐ Medrol Dose Pack (4 mg) #21, 5 refills. Use as directed.

Patients with "Cold Sores": ☐ Valtrex Tablets (1000 mg) ii po bid evening before Tx x 2 days #30, 5 refills