Premier Aesthetics, LLC

4553 N. Shallowford Rd. Suite 50C
Atlanta, GA 30338
770-457-1708

Patient Information

Date _____ Full Name _____ Nickname _____

Address _____ City _____ State _____ Zip code _____

Home # _____ Cell # _____ Work # _____ Ext. _____

Email _____ D.O.B. _____ Age ____ Sex ____ Race _____ Marital Status _____

Occupation _____ **Would you like to receive our quarterly newsletter via email? Yes No**

Referral source: **Please be specific.** _____ Emergency contact: _____

Please check next to the procedures or treatments you are interested in.

____ Botox
____ Injectable Fillers (Restylane, Radiesse, Sculptra)
____ Skin toning of pore refining
____ Skincare products
____ Laser facial peels (Arctic Peel)
____ Acne treatment
____ Fine lines and wrinkle treatment
____ Facial cosmetic surgery
____ Brown / age / sun spot treatment
____ Laser hair removal
____ Spider veins / leg vein treatment
____ Chemical peels
____ Broken capillaries on the face
____ Facial Redness
____ Permanent Cosmetics
____ Body cosmetic surgery

Other interests not listed: _____

Do you use: Tobacco? ___yes ___no How much?_____ Quit? When?_____
Alcohol? ___yes ___no How much?_____ Quit? When?_____

Please check next to any current or past medical condition or treatment.

Pregnant or breast feeding	___yes	___no	Explain _____
Bleeding / clotting abnormalities	___yes	___no	Explain _____
Fever blisters / cold sores	___yes	___no	Explain _____
Keloid or thick scarring	___yes	___no	Explain _____
White of brown scarring	___yes	___no	Explain _____
Dark spots after pregnancy	___yes	___no	Explain _____
Lupus or other autoimmune deficiency	___yes	___no	Explain _____
Psoriasis or Vitiligo	___yes	___no	Explain _____
Diabetes	___yes	___no	Explain _____
Epilepsy	___yes	___no	Explain _____
HIV / AIDS	___yes	___no	Explain _____
Hepatitis	___yes	___no	Explain _____
Hirsutism	___yes	___no	Explain _____
Rheumatoid arthritis “Gold Therapy”	___yes	___no	Explain _____
Pulmonary embolism / blood clot	___yes	___no	Explain _____
Leg ulcers or phlebitis	___yes	___no	Explain _____
Accutane treatment	___yes	___no	Explain _____
Transplant anti-rejection drugs	___yes	___no	Explain _____
Blood thinning medication	___yes	___no	Explain _____
Waxing, plucking, electrolysis within last 6 weeks	___yes	___no	Explain _____
Chemical or laser peels, resurfacing, or facial surgery	___yes	___no	Explain _____
Do you have any drug or latex allergies?	___yes	___no	List _____

List any medications, vitamins, or herbal supplements you are taking. _____
List any other pertinent medical or surgical history. _____

The information provided above is complete and accurate to the best of my knowledge and I understand that I am fully responsible for payment of services rendered. I also authorize Dr. DeJoseph or any assistant he may designate to take photographs for pre- and post-operative evaluation purposes. These photos will remain the doctor’s property.

Sign _____ **Date** _____