Woodlands
Medical Aesthetics Institute

CLIENT INFORMATION FORM

Name:_____ Today's Date: _____

(Last) (First) (Middle)

Date of Birth:_____Age:_____Occupation: _____

Home Address: _____

City:_____State:_____Zip: _____

Cell Phone: _____Work Phone:_____Home Phone:_____

E-Mail Address:_____

Emergency Contact:_____ Phone Number: _____

How did you hear about us? _____

Marital Status (check one): ( ) Married ( ) Divorced ( ) Widow ( ) Living with Partner ( ) Single

May we call home, work or cell phone number to confirm future appointments? ____Yes ____No

May we contact you via email to confirm appointments and send our promotions? ___Yes ____No

PREFERRED METHOD OF CONTACT: ☐ **Text** ☐ **Email** ☐ **Phone**

HIPPA Privacy Authorization Statement

Authorization for Use or Disclosure of Protected Information

I, _____, give my permission to have any and/or all of my medical information, including financial, released to the following persons:

Name:_____Relationship: _____

Home Phone:_____Cell Phone:_____Work: _____

WHAT PROCEDURES ARE YOU INTERESTED IN? (please circle)

Botox/Dysport	Laser Hair Removal	Chemical Peels	Sexual Health
Facial Fillers	Photofacials	Laser Acne Treatments	Skin Tightening
Physician Strength Skin Care	Improving Profile	Bio Identical Hormones	Microneedling
Laser Skin Resurfacing	Fat Reduction	Weight Loss	Dermaplaning
Cellulite Treatment	Body Sculpting	Vampire Facial	Vampire Facelift
Vaginal Rejuvenation	Hair Restoration	Wrinkles/Aging	Sun Damage Repair

PHOTOGRAPHY

By my signature below, I do___ or do not___ consent to the photographing or televising of the operation(s) or procedure(s) to be performed, including appropriate portions of my body, for medical, scientific or educational purposes, provided my identity is not revealed by the pictures.

Signature of client:_____ Date: _____