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New Patient Questionnaire

Today's Date_____Name_____Date of Birth_____

Address_____City_____State___Zip_____

Home Phone_____Cell phone_____

E-Mail Address

_____

Is it ok for us to contact you to check in by phone? **Y N** By postal mail? **Y N**
By email? **Y N** By text message? **Y N**

What is the best way for us to contact you to follow up and to thank you for your visit(s)? **Phone Email Text Postal Mail**

How did you hear about us?_____

- If you were referred by one of our patients, please let us know the name so that we may thank him or her.

Do you have any of the following conditions?

- ☐ Bleeding disorder
- ☐ Cancer
- ☐ HIV/AIDS
- ☐ Pregnancy
- ☐ Nursing
- ☐ Latex allergy
- ☐ Melasma
- ☐ Skin Sensitivity
- ☐ Other
- ☐ Active infection
- ☐ Rheumatic disease (Rheumatoid Arthritis; Lupus)
- ☐ Keloids
- ☐ Diabetes
- ☐ Organ transplant
- ☐ Frequent cold sores
- ☐ Vitiligo
- ☐ Multiple Allergies (food; environmental)

Are you currently taking any of the following medications/supplements?

- ☐ Ibuprofen/Naproxen
- ☐ Aspirin
- ☐ Warfarin (Coumadin)
- ☐ Fish oil
- ☐ Immunosuppressants
- ☐ Antibiotics
- ☐ Eliquis/Pradaxa/Xarelto
- ☐ Steroids (prednisone)
- ☐ Chemotherapy
- ☐ Retin-A

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Please list all current medications.

_____

Do you have any medication allergies?

_____

Do you tan or spend significant amounts of time outdoors in the sun? **Y N**
Do you smoke tobacco products? **Y N**
Would you say that you "bruise easily"? **Y N**

What would you like to **improve** about your skin/appearance?

- ☐ Brown Spots/Sun Damage
- ☐ Capillaries/Veins on face
- ☐ Drooping Mouth Corners
- ☐ Dark Circles Under Eyes
- ☐ Rough Skin Texture
- ☐ Lines and Wrinkles/Upper Face
- ☐ Lines and Wrinkles/Lower Face
- ☐ Loss of Lip Volume
- ☐ Loss of Cheek Volume
- ☐ Acne
- ☐ Acne Scars
- ☐ Loose Skin on Neck
- ☐ Jowls/Jawline laxity
- ☐ Deep Nasolabial Folds
- ☐ Smokers Lines
- ☐ Sun Damage on Neck/Chest
- ☐ Aging of Hands
- ☐ Sagging Eyelids
- ☐ Large Pores
- ☐ Loss of Brow Height
- ☐ Crepey Skin Under Eyes
- ☐ Unwanted Body Fat
- ☐ Loose skin on the body
- ☐ Cellulite

If you are interested in Body Contouring, what areas of your body are you interested in improving/contouring?

_____

Are you interested in learning more about prescription-grade anti-aging skin care products? **Y N**

Are you currently a member of the GALDERMA Aspire rewards program? **Y N**

We strive for the highest levels of customer satisfaction. If you have had any negative experiences at other centers, what were they?

_____
_____

Is there anything else that you would like us to know that would help us assist you best today?

_____
_____

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Cancellation and Refund Policy
Sonata has a no-refund policy for either pre-paid procedures/treatments or procedures/treatments already performed.

If you have pre-paid or put down a deposit for a treatment and cannot complete the procedure, you may apply these funds to other treatments or services in our office, per the discretion of office management.
You have one year from the time of payment to use the credited amount.

No Show/ Cancellation Policy
For surgical procedures and thread lifts:

If you must cancel your treatment, we require 48 hours notice of the cancellation. Please note that we are not able to take your call over the weekend. We require two business days of notice.

If you are not able to give us 48 hours notice, you will be charged a $250 re-booking fee.
For non-surgical treatments:

If you must cancel your treatment, we require 24 hours notice of the cancellation. Please note that we are not able to take your call over the weekend. We require one business day notice.

If you are not able to give us 24 hours of notice, you will be charged a $50 fee.

If you no show for a complimentary appointment, you will no longer be able to use that service.

Complimentary treatments have no cash value and cannot be transferred.

If you no-show or late cancel for a treatment that is part of a package, you will lose the value of that treatment in the package/or that series in the treatment package.

Our schedule is often booked weeks in advance and a late cancellation negatively impacts other clients who wish to schedule with our providers. We appreciate your consideration.
I understand and accept these policies.

Patient Signature _____

Our Mission at Sonata is to bring beauty, love, light and compassion to our amazing patients.

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