



## FACIAL AESTHETICS REGISTRATION

(Please print clearly)  
(Please mark the appropriate response)

First Name: \_\_\_\_\_ Preferred Name: \_\_\_\_\_

Last Name: \_\_\_\_\_ Marital Status: S M W D

Date of Birth: \_\_\_\_\_ Sex: M F

Social Security #: \_\_\_\_\_

Email: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home: \_\_\_\_\_ Work: \_\_\_\_\_ Cell: \_\_\_\_\_

Any known allergies? \_\_\_\_\_

In case of emergency, please notify: \_\_\_\_\_

Do you have any skin care concerns? \_\_\_\_\_

I was referred by: \_\_\_\_\_

**So that we may serve you better, please check any areas that you would like to receive more information on:**

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Teeth Whitening    | <input type="checkbox"/> Peel Treatments    | <input type="checkbox"/> Acne Treatment                   |
| <input type="checkbox"/> Eyelash Extensions | <input type="checkbox"/> Botox/Juv'ederm    | <input type="checkbox"/> Lip Plumping                     |
| <input type="checkbox"/> Facials            | <input type="checkbox"/> Cheek Augmentation | <input type="checkbox"/> Laser Hair Removal               |
| <input type="checkbox"/> Microdermabrasion  | <input type="checkbox"/> Gift Certificates  | <input type="checkbox"/> Treatment for sun spots/scarring |

### Financial & Appointment Policy

Payment for services rendered is due and payable at the time of treatment unless arrangements have been made in advance. We accept Cash, Personal Checks, Visa, & Mastercard.

Minor Children: The parent or guardian that brings a minor child in for treatment in our practice is responsible for payment for services.

Appointment Policy: We do not double-book appointments in our office and request 2 business days notice for all cancellations of appointments. We ask for your cooperation in managing your appointments so that we can maintain the highest level of access to care possible at all times for each of our valued patients.

I have been informed of Total Transformation Dental and Spa's financial and appointment policies. I agree to be responsible for all fees for services and materials incurred during the course of my treatment.

\_\_\_\_\_  
Signature of Patient or Responsible Party

\_\_\_\_\_  
Date