

3935 I-49 South Service Road· Opelousas, LA 70570 Phone (337)594-6002 · Fax(888)491-1354

Today's Date

AESTHETIC CONSULTATION FORM

Last Name:	First N	ame:	
Date of Birth:	Gender:	_ Email:	
Address:			
City:	State:	Zip Code:	
Phone Number:	Alternate r	number:	***************************************
Emergency Contact Name: _		Phone:	
	eation allergies? If ye		
Please list all medications/su	pplements:		
	ou could be pregnant?		
Have you ever had a cold sor	e?		
What is your skin type and co	oncerns?		
Current skincare regimen:			
What are your skin goals?			

No Show Policy

Our goal is to provide quality individualized aesthetic care in a timely manner. In order to be respectful to our staff and other patients, please call Trahan ENT & Aesthetics promptly if you are unable to show up for an appointment. If it is necessary to cancel your scheduled appointment, we advise that you call atleast 24 hours in advance. A "no-show" is someone who misses an appointment without cancelling it in an adequate manner. All aesthetic appointments will be held with a credit card.

Failure to show for your appointment will result in a \$50.00 NO SHOW FEE that will be charged to the card on file.





SKINCARE AND PHOTOGRAPHY INFORMED CONSENT

PATIENT NAME:

DOB:
etic personnel are not a cure-all epidermal treatment. dures can provide marked improvement in the appearance of ou have a thorough understanding of what an aesthetic skin condition or skin type. In addition, it is imperative that th the certain procedures.
list of all possible complications , which could arise as a result
al and subsides after a short duration. Incare service you are receiving. Ire, or pigmentation the may occur at the junction between is not common. Is pots, and blood vessels may become more obvious after a eing removed. It pected to grow back blunt-ended. New hair will not appear
ny permission for the use of photographs and videos for the ials below:
ns and videos may be published by Trahan ENT and Aesthetics s email, social media, website, and other marketing
and Aesthetics from all rights that I may have in the relating to such use.
ary.
inical photographs and videos to be published.
and release.
Date:
Date:

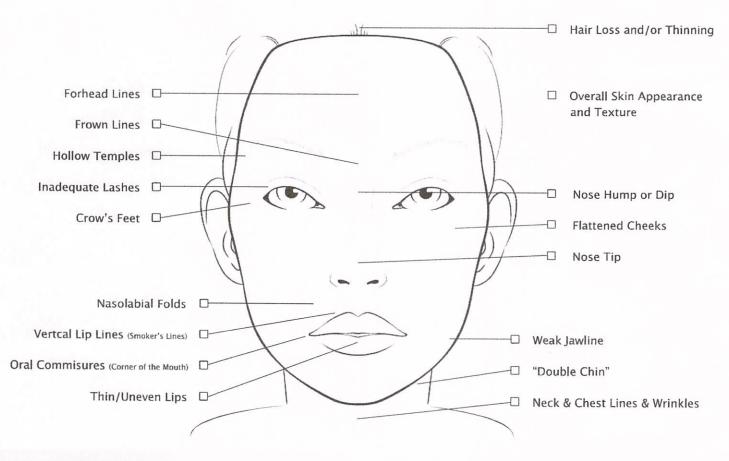
SELF-ASSESSMENT

Please complete and return this form to the front office before your consultation.

NAME:			DATE OF BIRTH:		DATE:	_
What b	rings you in today?					
	Othe what addition	er than th	e services we have already provided f s would like to learn about? Please ch	or you,	that apply	
	Skin care advice		Facial veins			
	Skin care products		Facial redness		Scar revision Breast size	
	Facial injectables/fillers				Abdominal area	
	Facial fine lines/wrinkles		Brown spots/age spots/freckles Drooping brow			
	Thin lips			100	Hips	
	Length of eyelashes		Drooping eyelids Nose size or shape		Legs	
	Fullness of eyelashes		Facial fullness/drooping		Facial contouring	
	Darkness of eyelashes		Mole removal		Body contouring	
	Chemical peel			ш	Unwanted hair	
	Blotchy skin		Neck wrinkles Make up			

Select which areas of the face concern you on the diagram below.

By sharing how you see yourself, we can best evaluate your aesthetic goals and select an appropriate treatment for you.



Your Top 3 Areas of Concern:

Your Treatment Plan Timeline (FOR OFFICE USE ONLY)

- 1.
- 2.
- 3.