Silverado Medical [Aesthetics]
PATIENT DEMOGRAPHIC SHEET

Name: _____ Date: _____
Please Print

Occupation: _____ Gender: ☐ *Female* ☐ *Male*

Marital Status: _____ Date of Birth: _____ AB Health Number:_____

ADDRESS:

Street: _____ City: _____ Prov: _____ Postal Code: _____

Phone: _____Cell: _____**Phone Carrier**: _____Other: _____
(for SMS reminders)

Email: _____

Would you like to be notified of special events, promotions, new products or services? You can unsubscribe at any time. ☐ Yes ☐ No

How would you prefer to be contacted? _____

Emergency contact: _____ Phone: _____

How did you hear about Silverado Medical?

_____

ALLERGIES: Please list all allergies both prescription and non-prescription:

_____

MEDICATION: Please list any medications you are currently taking and dosage, including all medications taken within the past month, vitamins and herbal remedies:

_____

Are you currently being treated for any medical condition? If so, explain:

Have you had any surgeries? If so, what kind and when:

_____

_____

Please list below any questions you would like to have specifically answered during your consultation.

_____

_____

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MEDICAL HISTORY

1.	Are you pregnant	○ Yes	○ No
2.	Breast Feeding	○ Yes	○ No
3.	Planning a pregnancy	○ Yes	○ No
4.	Do you smoke	○ Yes	○ No
5.	History of Cold Sores	○ Yes	○ No
6.	History of skin cancer/ precancerous lesions	○ Yes	○ No
7.	History of Keloids	○ Yes	○ No
8.	History of Cancer	○ Yes	○ No
9.	Autoimmune disorders	○ Yes	○ No
10.	Multiple Sclerosis	○ Yes	○ No
11.	High blood pressure	○ Yes	○ No
12.	Seizures	○ Yes	○ No
13.	Diabetes	○ Yes	○ No
14.	Blood clots/Bleeding disorders	○ Yes	○ No
15.	HIV/AIDS	○ Yes	○ No
16.	Hepatitis	○ Yes	○ No
17.	Are you on a blood thinner	○ Yes	○ No
18.	Have you been on Accutane in the past 6 months	○ Yes	○ No
19.	Have you had gold injections in the past	○ Yes	○ No
20.	Are you ingesting any products with silver	○ Yes	○ No
21.	Pacemakers/internal pacing devices	○ Yes	○ No
22.	Internal metal devices (rods, plates, implants)	○ Yes	○ No
23.	Do you have dental implants	○ Yes	○ No
24.	Do you have abdominal hernia or had previous hernia surgery	○ Yes	○ No

Have you ever had the following cosmetic procedures:

1.	Permanent Makeup	○ Yes	○ No
2.	Injected fillers	○ Yes	○ No
3.	Botox	○ Yes	○ No
4.	Chemical Peels	○ Yes	○ No
5.	Microdermabrasion	○ Yes	○ No
6.	Laser Treatments	○ Yes	○ No
7.	CoolSculpting	○ Yes	○ No
8.	Cosmetic Surgery	○ Yes	○ No

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What service(s) are you interested in:

1. Botox	○ Yes	○ No
2. Dermal Filler	○ Yes	○ No
3. CoolSculpting (body contouring)	○ Yes	○ No
4. Skin Tightening	○ Yes	○ No
5. Double Chin Treatment	○ Yes	○ No
6. Hair Loss Treatment	○ Yes	○ No
7. Acne Treatment	○ Yes	○ No
8. Acne Scar	○ Yes	○ No
9. Pigmentation (sunspots/age spots) Reduction	○ Yes	○ No
10. Redness (vessels, rosacea)	○ Yes	○ No
11. Masseter Muscle Injection	○ Yes	○ No
12. Scar Reduction	○ Yes	○ No
13. Hair Reduction	○ Yes	○ No
14. Excessive Sweating Treatment with MiraDry	○ Yes	○ No
15. Vaginal Rejuvenation	○ Yes	○ No
16. Laser Vein Treatment	○ Yes	○ No

Please list any concerns you have with your skin's appearance:

_____

What products are you currently using on your skin:

_____

How would you like to pay: ☐ Visa ☐ Mastercard ☐ Debit ☐ Cash ☐ Financing

Silverado Medical Aesthetics is committed to providing all of our patients with exceptional care. When a patient cancels without giving enough notice, they prevent another patient from being seen.
Please call us at (403) 873-8999 by 4:00 p.m. one day prior to your scheduled appointment to notify us of any changes or cancellations. To cancel a Monday appointment, please call our office by 4:00 p.m. on Friday. If prior notification is not given, you will be charged $50 for the missed appointment

_____ _____
Name *(please print)* Date

_____ _____
Signature Date

PRACTICE FINANCIAL POLICY

Unless other arrangements have been made in advance, full payment is due at the time of service.

Silverado Medical Aesthetics | #802, 19369 Sheriff King Street SW, Calgary, Alberta, T2X 0T9
info@silveradomedical.ca

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