PAIN INSTACARE-COSMETIC BOTOX

REGISTRATION

Name: _____ DOB: _____ Sex: M/F

Address: _____

Phone: Cell-_____ Work- _____ Home- _____

Email: _____

How did you hear about us: Friend:_____ Facebook/ Social / TV/Billboard/Online/Newspaper/Magazine

ALLERGIES: _____Medications: _____ Any blood thinners: Yes/No

PROGRAMS INTERESTED IN:

BOTOX	FILLERS	SKIN REJUVENATION	SKIN WHITENING
TATOO REMOVAL	HAIR REDUCTION	BODY CONTOURING	LIPOSUCTION

INSTASLIM WEIGHT LOSS (Usually 1 month program patient lose about 2-5lb/week if followed)

AREAS OF CORNERNS

PREVIOUSLY TREATED: YES_____(where)_____ / who _____/No. of units_____

Results: _____

MEMBERSHIP: START DATE_____ **REFERRALS: _____**

PATIENT NAME:

TREATMENTS

Date: __________________Total Units: Suggested/ Injected_______________ Wt. Loss __________ Amount Charged: _____________

Comments:

Date: __________________Total Units: Suggested/ Injected_______________ Wt. Loss __________ Amount Charged: _____________

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Comments:

PATIENT NAME:

TREATMENTS

Date: ____________________**Total Units: Suggested/ Injected**________________ **Wt. Loss** ___________ **Amount Charged:** ______________

Comments:

Date: ____________________**Total Units: Suggested/ Injected**________________ **Wt. Loss** ___________ **Amount Charged:** ______________

Comments:

Date: ____________________**Total Units: Suggested/ Injected**________________ **Wt. Loss** ___________ **Amount Charged:** ______________

Comments:

Date: ____________________**Total Units: Suggested/ Injected**________________ **Wt. Loss** ___________ **Amount Charged:** ______________

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Date: ____________________**Total Units: Suggested/ Injected**________________ **Wt. Loss** ___________ **Amount Charged:** ______________

Comments:

PATIENT NAME: