Registration Form

Name (First, Last): ____

Address: ____________________________________ City: _________________________ Prov:_________PC: _________

☐ Home: (   )___________________ ☐ Cell: (   )______________________ ☐ Work: (   )____________________

Gender: ☐ Female ☐ Male Preferred Pronoun: _____________________

Date of Birth: (MM/DD/YEAR): ___________/_________/_______ BC Carecard #: ________________________________

Email Address: ____

Preferred Method for Appointment Confirmations:

☐ Phone call ☐ Email

☐ Text ☐ Do not confirm*: I understand failure to show up for an appointment will result in $50.00 charge*

Newsletters and Appointment Confirmations (via text and/or email):

☐ Yes, I would like to receive monthly Newsletters and VIP promotions. I understand I can withdraw consent at any time by contacting us at (604) 298-4481 or by submitting Unsubscribe

☐ No, I do not want to receive monthly Newsletters or VIP promotions

How did you hear about us? (Please check all the apply)

☐ Google ☐ Facebook, Instagram

☐ Bing, Yahoo, Yelp ☐ Advertisements/periodicals

☐ Other Search Engine ☐ Seminar / Lunch & Learn

☐ Website ☐ Walk by / Drive by

☐ Family/Friend (name): ____

Sun History & Lifestyle

How often do you work outdoors?	☐ Frequently	☐ Occasionally	☐ Never
How often do you use sunscreen?	☐ Frequently	☐ Occasionally	☐ Never
How often do you use tanning beds?	☐ Frequently	☐ Occasionally	☐ Never

Do you have any of the following Medical Conditions? (Please check all that apply)

☐ Cold Sores ☐ Diabetes ☐ Epilepsy ☐ Hepatitis A,B,C ☐ Herpes ☐ Genital Warts

☐ Arthritis ☐ HIV/AIDS ☐ Lupus ☐ Keloid Scars ☐ Migraines ☐ Psoriasis

☐ Thyroid Imbalance ☐ Headaches triggered by lights ☐ Blood Clotting Abnormalities

☐ High Blood Pressure ☐ Any Active Infection ☐ Hormone Imbalance

☐ Cancer, if yes, what type and when? ____

Do you have any other health problems or medical conditions? (Please list) ☐ None

____

____

Please list Past Surgical History, procedure and what year? ☐ None

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____

____

Have you ever had sclerotherapy, EVLT or phlebectomy? ☐ Yes ☐ No

Please list all Medications you are currently taking (including vitamins and minerals): (Please list) ☐ None

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____

Are you taking HRT or Steroids? ☐ Yes ☐ No

Have you ever taken Accutane? ☐ Yes ☐ No

If yes, when did you finish your treatment? ______________________________

Please list all Allergies (medications, products and/or general allergies): ☐ None

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For our Female Clients:

Are you pregnant? ☐ Yes ☐ No

Are you trying to become pregnant? ☐ Yes ☐ No

Are you breastfeeding? ☐ Yes ☐ No

I certify that the preceding medical information is correct. I am aware that it is my responsibility to inform the doctor or other health care professional of my current medical or health conditions. A current medical history is essential to execute appropriate treatment procedures.

______________________________________ ______________________

Signature: Date:

On occasion there may be Physicians or Technicians-in-training on site to observe clinic consultations and/or procedures. You may refuse to have outside observers at any time. Do you consent to these physicians and/or technicians observing your treatment at our clinic?

______________________________________ ______________________

Signature: Date:

Revision July 02, 2023