SKINN
MEDICAL & AESTHETICS

PATIENT INFORMATION & CONSENT FORM

Patient Details:		
Full Name:		
ID / Passport:		
DOB:	YYYY/MM/DD	
Contact:	+27 (……)	
Email:		
Address:		
	Postal Code:	

Medical Aid Details: ……

Scheme: ……

Plan: ……

Member No: ……

Main Member: ……

Medical History (Tick if applicable):

Allergies	
Pregnancy/Breastfeeding	
Chronic Conditions	
Medication	
Previous Aesthetic Treatments	
Skin Conditions	
Keloid Scarring	

Consent (POPIA & Treatment):
I consent to processing of my personal and medical information and to receive treatment. ☐

Third Party Sharing:
I consent to sharing with medical aids, labs, attorneys or debt collectors, if required. ☐

Financial Responsibility:
I accept responsibility for all costs and outstanding balances. ☐

Aesthetic History (Tick if applicable):

Recent Chemical Peels	
Recent Botox	
Recent Fillers	
Known Botox resistance	
Bleeding disorder	
Previous reaction to any previous aesthetic procedures	

Aesthetic Treatment (Tick if applicable):

General Aesthetic Treatment	
Botox	
Fillers	
Chemical Peels	

Patch Test (Tick if applicable):

Patch test required	

Photo Consent:

Medical records only	
Marketing (identity protected)	

Appointment Policy:
24-hour cancellation notice required. Late cancellations may be charged.

Disclaimer:
Outcomes are not guaranteed. Risks explained and accepted.

Signature:

Patient Name: ……

Signature: …….. Date: ……..