Dr. R. van Aardt
Cosmetic Medicine

SKIN ANALYSIS EVALUATION

__ TRURO __ VITALITY __ VIBE

Date: _____

Name: _____ Date of Birth: _____

Contact Tel # (Cell): _____-_____-_____ (W): _____-_____-_____ (H): _____-_____-_____

Email: _____ Consent to use: __Y __N

Address: _____

Primary Skin Concerns: _____

I hereby authorize the clinical skin consultant and medical staff of this Medi-Spa, to perform aesthetic and medical examinations and diagnostic and treatment procedures on myself or the patient named.

_____ _____ _____

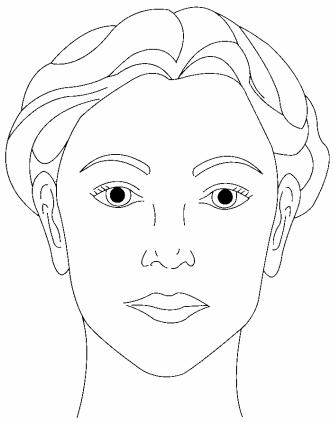
Name of Patient/Client Signature Date

OFFICE USE ONLY - CLINICAL SKIN CARE EVALUATION

Visible Complexion:

__ Fair __ Muddy __ Tanned __ Shiny __ Flushed __ Dull __ Jaundiced

Notes:



Attach any print outs from Smart Mirror-Skin Analysis System

_____

Signature of Attending Physician/Service Provider