

*Dr. Mel's Wellness Spa Services*

916 SE Cape Coral Parkway  
Cape Coral, FL 33904  
239-542-1422

Name\_\_\_\_\_

Address\_\_\_\_\_

City\_\_\_\_\_ State\_\_\_\_\_ Zip\_\_\_\_\_

Phone#\_\_\_\_\_ Cell\_\_\_\_\_ Email\_\_\_\_\_

Birthdate\_\_\_\_\_ Is this your first Facial? Y N

Referred by?\_\_\_\_\_

\*All information is kept confidential and for our office use only\*

Do you have any allergies to drugs or herbs? Please list\_\_\_\_\_

Any history of skin problems or skin cancer?\_\_\_\_\_

Are you currently pregnant?\_\_\_\_\_

Are you presently taking any medications or aspirin? Please list\_\_\_\_\_

Are you currently using (or used in the past) Renova/ Retin-A/ Facial Injectables

What products do you currently use on your skin? Soap/Cleansers Toner

Exfoliants/Scrubs Treatment Products Moisturizers Sunscreen

**IRREVOCABLE AGREEMENT FOR PAYMENT**

I clearly understand and agree that all services rendered by Dr. Mel's Wellness Spa, are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care, that any fees for professional services rendered to me will be immediately due and payable.

I understand that as I am accepted as a patient of Dr. Mel's Wellness Spa Services, I authorize Dr. Mel and her staff to proceed with any spa services requested by me. Furthermore, any risks associated with the spa services provided, will be explained to me upon my request

I understand that the services offered are not a substitute for medical care and any information provided by the therapist is for educational purposes only and not diagnostically prescriptive in nature.

Client's signatureX\_\_\_\_\_