
WELCOME TO AESTHETIC CENTER OF SANTA CLARITA, INC.

We are delighted to take care of your Aesthetic needs and will provide personalized attentive service. Please help us serve you best by completing the information requested below. Please feel free to come to us with any questions. We are happy to help you. Please complete this for prior to your visit.

## PERSONAL INFORMATION

DATE: _____

NAME: _____ DOB : ____/____/_____AGE _____

ADDRESS: _____

CITY/STATE/ZIP : _____ COUNTRY : _____

SSN : ____ - ____ - _____ ___SINGLE ___MARRIED ___ WIDOWED ___ SEPARATED ___ OTHER

EMPLOYER : _____

REFERRED BY : _____ PRIMARY PHYSICIAN : _____

PHYSICIAN PHONE # & ADDRESS : _____

## CONTACT INFORMATION

HOME PHONE : _____ MOBILE PHONE : _____

WORK PHONE : _____ EMAIL ADDRESS : _____

(WE PREFER & ENCOURAGE E-MAIL FOR COMMUNICATION, IT'S FAST & EFFICIENT)

DO YOU PREFER : ____ E-MAIL ____ MOBILE # ____ HOME ____ WORK

EMERGENCY CONTACT : _____ RELATIONSHIP : _____

MOBILE # _____ WORK # _____ HOME # _____

## FINANCIAL AGREEMENT

PLEASE READ THE FOLLOWING:

I understand that I am financially responsible for all charges. I understand that Aesthetic Center of Santa Clarita Inc./ Dr. Courtenay Poucher, does not accept insurance as a form of payment. I understand that cash, cashier's check, all major credit cards & Care Credit are the accepted forms of payment and all payments are to be made before service is rendered.

SIGNATURE : _____ DATE : _____

PRINTED NAME : _____


History and Physical Date _____

Patient Name _____ Date of Birth _____
Age _____ First Day of Last Menses _____
Occupation _____
Referred by:_____

Chief Complaint
_____
_____

Interested in Aesthetic Vaginal Surgery

__ I want AVS
__ My labia are larger/looser than I want
__ I do not like the way my labia looks
__ My labia rub, tug, and pull on clothing
__ I am unable to wear clothing I want
__ I have had unflattering comments about my genital region
__ I had difficult births
__ My vagina feels too loose inside
__ I have decreased sensations
__ Sex is uncomfortable/unpleasant
__ I rely on my appearance at work
__ I am interested in G-Spot augmentation

Medical History
# of Pregnancies ____ #Births Vaginal ____C/S ____ #Miscarriage ____
Allergies to Meds _____ or ___None
Current Medications Taken _____
Tobacco Y/N Alcohol Y/N Caffeine Y/N Drugs Y/N
____ mark here if none of the issues listed below exist

Diabetes
Hypertension (high blood Pressure)
Thyroid Disease (low or high)
Bleeding Problems/Thrombophilia or Blood Dyscrasia
Anxiety
Depression
Herpes
STD
Abnormal Pap Smear
Prior Surgery (please list below):
_____
_____
_____