Confidential Intake Form

(Aesthetics)

Date: May 1, 2026

Patient Information

- **Patient Name:** Patie
- **Date of Birth:** Patient DOB Select Date

Consent Statement

I acknowledge that I have read and understand the information provided about this treatment/service. I have been given the opportunity to ask questions and all my questions have been answered to my satisfaction.

I agree to the terms and conditions described above

Signature

Patient Signature: (Sign below)

Date: May 1, 2026

Medical Services provided by Primary Medical of KY, P.S.C., Elite Health Services, P.A., Co., Primary Medical of IN, P.C.

Signature Certificate

Document name: Confidential Intake Form

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LEGALLY SIGNED USING WPesignature
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