

# Patient Registration

Please fill out **everything** to the best of your knowledge



Patients Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Date Of Birth: \_\_\_\_\_ Email Address: \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ Alternate Phone Number: \_\_\_\_\_

Please Provide Cell Phone Carrier For Appointment Reminders (Please Circle One)

Altell AT&T Boost Nextel Sprint SunCom T-Mobile Verizon Other \_\_\_\_\_

In case of an emergency, please list a contact name: \_\_\_\_\_

Relationship: \_\_\_\_\_ Phone number: \_\_\_\_\_

How did you hear about us? \_\_\_\_\_ Referred by: \_\_\_\_\_

In the event we need to call in a prescription for you, please provide your preferred pharmacy information.

Pharmacy Name: \_\_\_\_\_ Location/Phone #: \_\_\_\_\_

## SKIN PRODUCT HISTORY

Do you currently use skincare products as a daily regimen? **Yes No**

If yes, list products used \_\_\_\_\_

Have you done any aggressive exfoliation to your skin in the last 2 weeks? **Yes No**

If yes, explain type(s) of exfoliation \_\_\_\_\_

## SKIN PROCEDURE HISTORY

Have you previously had any of these skin procedures (treatments)? **Yes No** If no, skip this section.

Microdermabrasion Yes No Date of last procedure \_\_\_\_\_

Chemical Peel Yes No Date of last procedure \_\_\_\_\_

Phototherapy Yes No Date of last procedure \_\_\_\_\_

Laser Resurfacing Yes No Date of last procedure \_\_\_\_\_

Radiofrequency Yes No Date of last procedure \_\_\_\_\_

Dermaplaning Yes No Date of last procedure \_\_\_\_\_

Facial Surgery Yes No Date of last procedure \_\_\_\_\_

Botox Yes No Date of last procedure \_\_\_\_\_

Fillers Yes No Date of last procedure \_\_\_\_\_

Laser Hair Reduction Yes No Date of last procedure \_\_\_\_\_

Other procedures/date? \_\_\_\_\_

**CONTINUE TO BACK**

**OILY SKIN OR ACNE**

Any acne breakout?  Blackheads  Whiteheads  Enlarged Pores  Pustules  Large pores  Cysts

Do you have any history of acne or periodic breakout? **Yes No**

Do you only experience breakout during or around your menstrual cycle? **Yes No**

Do you always have a pimple or some type of breakout? **Yes No**

Does your skin ever flake or feel tight and dry? Frequently? Occasionally? Never?

Is your skin ever shiny (oily) a few hours after cleansing? Frequently? Occasionally? Never?

How noticeable are your pores? Very? T-Zone only? Not Very Noticeable?

Have you ever been diagnosed with Rosacea? **Yes No**

**Fitzpatrick Scale**

How does your skin react to sun exposure?

**I** Burn **II** Usually Burn **III** Sometimes Burn **IV** Rarely Burn **V** Only Tan **VI** Never Burn

Do you ever use tanning beds? **Yes No** If yes, when? \_\_\_\_\_

Do you currently wear a sun protection product all day, every day? **Yes No**

Did your skin become darker after pregnancy? **Yes No**

Do you have skin discoloration? Even Uneven Birthmark(s) Pregnancy Mask Sun Damage

What is your ethnicity and race? \_\_\_\_\_

How do you want to improve your skin? \_\_\_\_\_

If you are interested in Laser Hair Reduction, what area(s) are you interested in treating?

\_\_\_\_\_

I confirm, to the best of my knowledge, that the answers I have given are correct and that I have not withheld any information that may be relevant to my treatment(s).

I understand that some skin conditions may require more than one treatment and home care products to achieve the results desired. Results cannot be guaranteed due to individual skin types and conditions.

Appointment information is considered "protected Health Information" under HIPPA. Your privacy and medical information will only be shared internally within our medical office.

*\*\*Please be aware appointment reminders are a courtesy. Please refer to the enclosure regarding our cancellation/no show and other appointment policies.*

**Patient Printed Name:** \_\_\_\_\_

**Patient Signature:** \_\_\_\_\_