Please be sure to fill out all information and sign. Payment is expected at time of service. If you have any questions, please speak with the receptionist. Thank you.

***Any record requested or sent by other Physicians **will not** be stored/kept in our office.*

Patient Registration

Today's Date:_____

Name (First, Middle, Last): _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

DOB: _____ SSN: _____ Sex: (M) (F) Marital Status: (S) (M) (D) (W)

Email: _____

Are you of Hispanic or Latino decent? (Yes) (No) If yes, from what region? _____

*****Please circle the below number at which you would prefer us to leave messages.*****

Home: _____ Mobile: _____ Work: _____

Permissions

- ☐ Yes I give permission to verbally discuss my medical condition(s), treatment, and information regarding my treatment with the following individual(s):

  _____/_____
  Name/Relationship

  _____/_____
  Name/Relationship

- ☐ No, I do not give permission to discuss my medical condition(s), treatment, and information regarding my treatment with anyone else.

- Permission to send appointment reminders by email? ☐Yes ☐No

- Permission to access your medication list from the national database? ☐Yes ☐No

- Leave a message with Pathology/Lab results? ☐Yes ☐No

Note: If you answer "no" to the above question, you will be responsible for returning our call to receive your pathology and/or lab results.

Emergency Contact Information

Contact Name: _____ Relationship to Patient: _____

Home: _____ Mobile: _____ Work: _____

If Minor

Parent/Guardian: _____ Relationship to Patient: _____

Occupation *If minor provide parents*

Position_____ Employer Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Primary Insurance Information

Insurance Company: _____ ID# _____ Group # _____

Patient's Relationship to Insured Party: (Self) (Spouse) (Child) *SSN is required for Primary Holder*

Name of Policy Holder: _____ DOB: _____SSN:_____

Address: _____City:_____State:_____Zip:_____

Home Phone: _____ Mobile Phone: _____ Work Phone: _____

Employer: _____ Occupation: _____

Secondary Insurance Information

Insurance Company: _____ ID# _____ Group # _____

Patient's Relationship to Insured Party: (Self) (Spouse) (Child)

Name of Policy Holder: _____ DOB: _____SSN:_____

Address: _____City:_____State:_____Zip:_____

Home Phone: _____ Mobile Phone: _____ Work Phone: _____

Vaccinations

Influenza (Flu) Immunization? □Yes □No **If yes**: date: (Month/Year) _____

Pneumococcal (Pneumonia) Vaccination? □Yes □No **If yes**: date: (Month/Year) _____

Primary Physician

Primary Physician: _____

How did you hear about us?

Doctor: _____Insurance:_____ Patient: _____Other:_____

Signature: _____Date: _____

HEALTH INFORMATION

Name: _____ Date of Birth: _____

Reason for Visit

What brings you to the office today?

_____
_____
_____

What cosmetic services are you interested in?

☐ Facial Fillers ☐ Sculptra ☐ Neurotoxin (Botox, Xeomin, Dysport) ☐ Revision Skin Care
☐ Laser Skin Treatments ☐ Laser Hair Removal ☐ Sunscreens ☐ Make-up, Jane Iredale

Review of Systems

Check those that apply:
☐ Bleeding Disorder Describe: _____
☐Pacemaker or Implanted Device Describe: _____
☐Do you require antibiotics prior to dental procedures due to a heart murmur?
☐Pregnant
☐Nursing
☐Trying to conceive

Past Medical History

Have you ever had any of the following?

☐Acne
☐Actinic Keratosis
☐Allergies
☐Arrhythmia
☐Arthritis
☐Asthma
☐Atopic Dermatitis
☐Atypical Nevi
☐Chronic Kidney Disease
☐COPD (Chronic Obstructive Pulmonary Disease)
☐Diabetes
☐Drug Dependency
☐Heart Failure
☐Hepatitis
☐Herpes Simplex Virus
☐Immune Disorder such as rheumatoid or psoriatic arthritis
☐High Blood Pressure
☐HIV
☐Keloid/Hypertrophic Scar
☐Loss of toe, foot, ankle or leg
☐Mood Disorder
☐Obesity
☐Psoriasis
☐Rosacea
☐Shingles
☐Skin Cancer:
  ☐Unknown
  ☐Basal Cell Carcinoma
  ☐Squamous Cell Carcinoma
  ☐Melanoma
  ☐Merkel Cell Carcinoma

Family History

Has anyone in your family ever had any of the following conditions?

☐Unknown-Adopted
☐Allergies
☐Asthma
☐Atopic Dermatitis
☐Autoimmune Disorders
☐Diabetes
☐Psoriasis
☐Skin Cancers:
  ☐Unknown Type
  ☐Basal Cell Carcinoma
  ☐Squamous Cell Carcinoma
  ☐Melanoma
  ☐Merkel Cell Carcinoma

Family History continued…

Any other family history that you think we should know of?
Details:_____
_____
_____

Lifestyle Factors

Have you ever smoked? □Yes □No # of years_____ # of packs/day_____
Do you smoke now? □Yes □No

Allergies

Are you allergic to any of the following?
□Lidocaine □Latex □Adhesive Tape

Please list any and all allergies to medications:
_____
_____
_____
_____

Current Medications

All medications including over the counter and/or supplements?
_____
_____
_____
_____

Pharmacy Information

Pharmacy Name: _____ Pharmacy Location: _____

Insurance Preferred Laboratory

_____

Height/ Weight for patient under the age of 18 for medications to be prescribed

Height: _____ Weight: _____

Signature: _____

Date: _____

Medical Assistant: _____