

CLIENT REGISTRATION

Name: _____ Date: _____

Address: _____ D.O.B: _____

City: _____ State: _____ Zip: _____

Phone: (home) _____ (cell) _____

(work) _____

Occupation: _____

E-mail: _____

Would you like to receive appointment confirmations via ... _____ Text _____ Email _____ Both
 Would you like to receive emails for monthly specials on products/services from us? Yes _____ No _____

Emergency Contact: _____ Phone: _____

Referred By: (circle one)

- | | | |
|---------------------------------------|-----------------------------------|--|
| <input type="checkbox"/> Phone Book | <input type="checkbox"/> TV | <input type="checkbox"/> Friend/Relative |
| <input type="checkbox"/> Newspaper | <input type="checkbox"/> Internet | <input type="checkbox"/> Magazine |
| <input type="checkbox"/> Other: _____ | <input type="checkbox"/> Radio | <input type="checkbox"/> E-mail Special |

Personal History Questionnaire

Are you allergic to latex?: YES NO

Please list any allergies: _____

Please check if you are being treated with any of the following products:

- Efudex Aldara LN2 for Actinic Keratoses Carac Solaraze

Please fill in your current skincare regimen: (list brand names)

Cleanser _____ Toner/Astringent _____
 Moisturizer (AM/PM) _____ / _____
 Eye Cream/Gel _____ Mask _____
 Surface Peel/Facial Exfoliator _____

Check the following that apply:

- Pimples Whiteheads Blackheads Enlarged Pores
 Acne Scars Cysts Flakiness

Are you currently taking Accutane (Isotretinoin) or have been within the past six months?

- YES NO

Are you currently taking antibiotics? YES NO

What is your approximate sun exposure time per week?

Occupational: _____ Recreational: _____

Do you currently have or have you had:

Pacemaker	Y/N	Hepatitis	Y/N	Diabetes	Y/N	Cancer	Y/N
Dental Fillings	Y/N	Menopausal Symptoms	Y/N	Lupus	Y/N		
Hypertension	Y/N	Herpes	Y/N	HIV/AIDS	Y/N		

Please check YES or NO in response to the following questions:

YES

NO

Are you currently taking or using Retin-A, Renova, Tazorac,

Differin, or Hydroquinone?.....

Are you currently pregnant or trying to get pregnant.....

Do you have a history of cold sores?.....

Do you use a daily sunscreen of SPF 15 or higher?.....

Do you use tanning beds?.....

Are you currently under a physician's care?.....

If yes, what is the doctor's name? _____

Are you currently taking hormone replacement therapy?.....

Are you considering facial cosmetic surgery?.....

Are you currently having facial waxing, electrolysis, or using depilatories?.....

Have you recently been treated with cosmetic fillers (Juvederm, Restylane) or Botox?....

Are you currently using any glycolic acid products?.....

Select the ONE description that would best describe you if you were exposed to strong sun with no sun block:

_____ 1. Always burn and never tan

_____ 2. Always burn, sometimes tan

_____ 3. Sometimes burn, but I always tan

_____ 4. Rarely burn, always tan

_____ 5. I have moderately pigmented skin

_____ 6. I have darkly pigmented skin

List what areas you are interested in having treated and your expectations after your treatment process:

Please be aware that we ask you to give us at least a 24-hour notice if you need to cancel or reschedule your appointment or there may be a charge for up to 50% of the cost of your appointment. This fee is non-refundable if you cancel with less than a 24-hour notice or if you are not a candidate for the scheduled procedure. This policy allows us to make your appointment available for other patients/clients waiting to be seen

FINANCIAL POLICY

*** Cosmetic services are elective and not covered by medical insurance. Payment is due at the time services are rendered. Please be aware we **do not accept Care Credit** as a form of payment.***

Print Name

Signature

Date