*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

- 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.*
- ☐ 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.

## 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: ________________

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## Advanced Care Planning

Does patient have an Advanced Care Plan/Surrogate decision maker (i.e. living will, medical power of attorney)? ☐ Yes ☐ No
If yes, name of decision maker & relationship:_____________________________________________

## Primary Physician

Primary Physician: ______________________________________________________

## Pharmacy Information

Pharmacy Name: _________________________ Pharmacy Location: _____________________________

**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?
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

## Insurance Preferred Laboratory

________________________________________________________________________

## Pharmacy Information

Pharmacy Name: __________________________ Pharmacy Location: ______________________________

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

Height: ____________________________ Weight: __________________________

**Patient Signature:** ____________________________________________________

**Date:** ______________________________________________________________

**Medical Assistant:** ____________________________________________________

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