New Patient Registration

General Information

Last Name: _____ First Name: _____ Middle Initial: ____

Street Address:

_____

City: _____

State_____ Zip: _____

Gender: ☐ M ☐ F Birth Date: _____ Age: _____ Occupation: _____

Cell Phone: _____ Alternative Phone: _____

E-Mail Address:

_____

Are you pregnant? ☐ Y ☐ N Breastfeeding? ☐ Y ☐ N Taking Antibiotics? ☐ Y ☐ N

Allergies:

_____

What problem are you concerned with?

_____

Please circle all that apply.

Face/Neck	**Body**	**Veins**
Acne/ Scarring	Hair Removal	Legs
Pigmentation/ Sun Damage	Moles/ Tags / Warts	Face
Fine Lines/ Wrinkles/ Large Pores	Body Contouring	Hands
Loose Skin	Pigment/ Sun Damage	Body
Botox & Fillers	_____	_____
Rosacea		

Would you be interested in Skin Care products?

☐ Skin Anti-Aging ☐ Skin Acne ☐ Skin Pigmentation/ Sun Damage

How did you hear about us?

_____

Would you like to join our e-mail list? ☐ Y ☐ N

We will keep you up to date via e-mail on new treatments, events and specials. Your privacy is important to you and us, and your information is kept confidential and not shared with other parties.

Please Complete if patient is a minor:

Person Completing Form: Last Name: _____ First Name: _____

Relationship to Patient: ☐ Mother ☐ Father ☐ Guardian ☐ Other _____

Emergency Contact:

Last Name: _____ First Name: _____

Middle Initial: _____

Relationship to Patient: _____ Phone Number: _____

Payment is due and payable at the time services are rendered. I understand I may receive separate bills for certain services provided outside this office, such as radiology or laboratory. I also understand I will be responsible for charges not covered by insurance. I certify that the information above is correct.

Signature: _____ Date: _____