Date:	**Registration**	MR #:

Last Name:	First Name:	M.I.:	Nickname:
Home Phone:	Work Phone:	Cell Phone:	Other Phone:
Home Address:			
City:		State:	Zip:
Employer:			
Work Address:			
City:		State:	Zip:

Occupation:			Circle One: Single Married Widowed Separated Divorced
Age:	Date of Birth:	Soc. Sec. #	Driver's License # and state:
In case of emergency, who should be notified?			Phone:

Please circle all of your concerns:

		Skin Care Consultation	Unwanted Hair	Skin Pigment Problems	Redness / Flushing	Blood Vessels
BOTOX	Restylane/Fillers	Fine lines/wrinkles	Acne / Pimples	Skin Texture	Spider Veins	Cosmetic Surgery -- Please complete the back of this form

Medical Information

Please LIST ALL medications you have taken in the past year, including over-the-counter, vitamin and herbal products. CIRCLE all medications you are currently taking:

ARE YOU ALLERGIC TO ANY MEDICATIONS OR FOODS? If YES, PLEASE LIST:

Have you ever had any injections for cosmetic purposes? ☐NO ☐YES If YES, please list: _____

Have you ever had:	YES	NO
Accutane		
Cold sore of the lip		
Facial nerve weakness, Bell's Palsy, eye conditions or neurologic conditions?		
Skin infections/Disorders		
Diabetes		
HIV+/AIDS		
Keloids		
Rosacea		
Hepatitis		
Tattoos / Permanent Makeup		
Skin cancer		

	YES	NO
Do you use any Retin-A products?		
Do you use alpha-hydroxy or glycolic based products?		
Are you ALLERGIC to latex or rubber?		
Have you used self-tanning or spray tan in the past 2 months?		
Have you used a tanning salon in the past 2 months?		
Are you on aspirin, Motrin, ibuprofen, Naprosyn, or other similar anti-inflammatory medications?		
Do you take any blood thinners like Coumadin or Plavix?		
Have you had vitiligo or loss of skin pigment?		
Have you had facial warts?		
Are you allergic to salicylates (ex. aspirin)?		
Do you have a pacemaker or cardiac rhythm problem?		

*** For Women Only ***

I am not pregnant or breast feeding and I fully consent to any therapies that would be considered unsafe during pregnancy or breast feeding.

X _____

I verify that the information on this registration form is true and accurate to the best of my knowledge.

X _____ Date _____

Signature of Client (or parent, if minor)

X _____

Relationship (if signing for minor)

Surgery Consultation Addendum

Please list ALL previous surgeries (include all cosmetic procedures and those from childhood):

Have you ever been hospitalized for any reason other than surgery? If so, please describe:

When was your last medical exam? With whom?

Who is your primary care physician? Name:

Address:

Telephone:

Do any illnesses run in the family? O NO O YES → If YES, which?

For Women only → No. of Pregnancies _____ Live births _____

Date of last mammogram _____ Last menstrual period _____

	YES	NO
Have you had any problems with anesthesia before?		
Have you taken any steroid medications within the past 12 months?		
Have you had any problems with scars or healing of your skin?		
Do you take diet pills or drinks?		
Do you use "recreational" drugs (ex. cocaine, marijuana, etc.) *This information is confidential*		
Have you ever had blood clots in your legs?		
Have you ever received chemotherapy?		
Have you ever received radiation therapy?		
Have you been seen or treated by a psychiatrist or psychologist?		

Please CIRCLE all conditions that you have had?

EASY BRUISING	HEPATITIS	HEART DISEASE	ASTHMA	HIGH BLOOD PRESSURE
ANEMIA	TUBERCULOSIS	THYROID DISEASE	STOMACH ULCER	MITRAL VALVE PROLAPSE
ARTHRITIS	RHEUMATIC FEVER	EYE DISEASES	HIV+ / AIDS	BLEEDING TENDENCY
STROKE	KIDNEY DISEASE	DEPRESSION	CANCER	BLOOD TRANSFUSIONS
		WEIGHT CHANGE		RAPID HEART RATE

Do you smoke? O NO O YES → If YES, what kind and how much per day? _____

If you are a former smoker, when did you quit? _____

Do you drink alcohol? O NO O YES → If YES, what kind and how much per week? _____

I verify that the information on this registration form is true and accurate to the best of my knowledge.

X_____ Date _____

Signature of Client (or parent, if minor)

X_____

Relationship (if signing for minor)