GAINESVILLE DERMATOLOGY
medical + surgical + cosmetic

CLIENT REGISTRATION

NAME			DATE / /	D.O.B
ADDRESS		CITY	ST	ZIP
PHONE	HOME	WORK	CELL	
EMAIL		OCCUPATION		
WOULD YOU LIKE TO RECEIVE EMAILS FOR APPOINTMENT CONFIRMATIONS AND MONTHLY SPECIALS ON PRODUCTS/ SERVICES FROM US?		☐ YES	☐ NO	
EMERGENCY CONTACT	NAME		PHONE	

REFERRED BY

☐ TV ☐ FRIEND/RELATIVE ☐ GNV DERM. MEDICAL + SURGICAL CENTER
☐ INTERNET ☐ MAGAZINE ☐ PHONE BOOK
☐ RADIO ☐ E-MAIL SPECIAL ☐ NEWSPAPER
☐ OTHER _____

PERSONAL HISTORY QUESTIONNAIRE

ARE YOU ALLERGIC TO LATEX?	☐ YES ☐ NO	
PLEASE LIST ANY ALLERGIES		
ARE BEING TREATED WITH ANY OF THE THESE PRODUCTS?	☐ EFUDEX ☐ ALDARA ☐ LN2 FOR ACTINIC KERATOSES ☐ CARAC ☐ SOLARAZE	
PLEASE LIST ALL PRODUCTS USED IN YOUR CURRENT SKINCARE REGIMEN	CLEANSER	EYE CREAM/GEL
	TONER/ASTRINGENT	MASK
	MOISTURIZER	SURFACE PEEL/EXFOLIATOR
CHECK THE FOLLOWING THAT APPLY TO YOU	☐ PIMPLES ☐ WHITEHEADS ☐ BLACKHEADS ☐ ENLARGED PORES ☐ ACNE SCARS ☐ CYSTS ☐ FLAKINESS	
HAVE YOU TAKEN ACCUTANE (ISOTRENTINOIN) IN THE PAST 6 MONTHS?	☐ YES ☐ NO	IF YES, ARE YOU CURRENTLY TAKING IT? ☐ YES ☐ NO
ARE YOU CURRENTLY TAKING ANTIBIOTICS?	☐ YES ☐ NO	
WHAT IS YOUR APPROX. SUN EXPOSURE TIME PER WEEK?	OCCUPATIONAL	RECREATIONAL
DO YOU CURRENTLY HAVE, OR HAVE YOU HAD ANY OF THE FOLLOWING? *(CHECK ALL THAT APPLY)*	☐ PACEMAKER ☐ MENOPAUSAL SYMPTOMS ☐ HIV/AIDS ☐ DENTAL FILLINGS ☐ HERPES ☐ CANCER ☐ HYPERTENSION ☐ DIABETES ☐ HEPATITIS ☐ LUPUS	

PERSONAL HISTORY QUESTIONNAIRE CONT.

PLEASE CHECK ***YES*** OR ***NO*** IN RESPONSE TO THE FOLLOWING QUESTIONS		
ARE YOU CURRENTLY TAKING OR USING RETIN-A, RENOVA, TAZORAC DIFFERIN, OR HYDROQUINONE?	☐ *YES*	☐ *NO*
ARE YOU CURRENTLY PREGNANT OR TRYING TO GET PREGNANT?	☐ *YES*	☐ *NO*
DO YOU HAVE A HISTORY OF COLD SORES?	☐ *YES*	☐ *NO*
DO YOU USE A DAILY SUNSCREEN OF SPF 15 OR HIGHER?	☐ *YES*	☐ *NO*
DO YOU USE TANNING BEDS?	☐ *YES*	☐ *NO*
ARE YOU CURRENTLY UNDER A PHYSICIAN'S CARE?	☐ *YES*	☐ *NO*
IF YES, WHAT IS THE DOCTORS NAME?	☐ *YES*	☐ *NO*
ARE YOU CURRENTLY TAKING HORMONE REPLACEMENT THERAPY?	☐ *YES*	☐ *NO*
ARE YOU CONSIDERING FACIAL COSMETIC SURGERY?	☐ *YES*	☐ *NO*
ARE YOU CURRENTLY HAVING FACIAL WAXING, ELECTROLYSIS, OR USING DEPILATORIES?	☐ *YES*	☐ *NO*
HAVE YOU RECENTLY BEEN TREATED WITH COSMETIC FILERS (JUVEDERM, RESTYLANE) OR BOTOX?	☐ *YES*	☐ *NO*
ARE YOU CURRENTLY USING ANY GLYCOLIC ACID PRODUCTS?	☐ *YES*	☐ *NO*

SELECT THE ONE DESCRIPTION THAT WOULD BEST DESCRIBE YOU IF YOU WERE EXPOSED TO STRONG SUN WITH NO SUNBLOCK

☐ ALWAYS BURN AND NEVER TAN
☐ ALWAYS BURN, SOMETIMES TAN
☐ SOMETIMES BURN, BUT I ALWAYS TAN
☐ RARELY BURN, ALWAYS TAN
☐ I HAVE MODERATELY PIGMENTED SKIN
☐ I HAVE DARKLY PIGMENTED SKIN

LIST WHAT AREAS YOU ARE INTERESTED IN HAVING TREATED AND YOUR EXPECTATIONS AFTER YOUR TREATMENT PROCESS

CANCELLATION POLICY

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 that a 24-HOUR NOTICE or if you are not a candidate for the scheduled procedure. This policy allows us to make your appointments available for other patients/clients waiting to be seen.

CLIENT SIGNATURE _____ *PRACTITIONER SIGNATURE* _____ *DATE* _____