

CLIENT REGISTRATION

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_ D.O.B: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: (home) \_\_\_\_\_ (cell) \_\_\_\_\_

(work) \_\_\_\_\_

Occupation: \_\_\_\_\_

E-mail: \_\_\_\_\_

Would you like to receive emails for appointment confirmations and monthly specials on products/services from us? Yes \_\_\_\_\_ No \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_

Referred By: (circle one)

Gainesville Dermatology

Phone Book

Newspaper

Other: \_\_\_\_\_

TV

Internet

Radio

Friend/Relative

Magazine

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  LN<sub>2</sub> 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