**Name:** ____________________________________________ **DOB:** ________________ **Age:** ______

**Address:** _________________________________________ **City:** _______________ **St:** ____ **Zip:**______

**Email address:**__________________________________ **Ok to send follow-up emails to this address?** ________

**Primary Telephone:** ___________________

**Are you interested in receiving practice promotions?** ______________________

**Who may we thank for referring you?** ____________________________________________

**PERSONAL DATA: Primary Care Physician:** ___________________________________

**PHARMACY NAME**____________________________ **LOCATION**___________________ **PHONE NUMBER**_______________

**The web is becoming a key way patients learn about our practice. Do you participate in any of the following? Facebook RealSelf Google**

***If you are a minor, who will be responsible for your account?***

**Name:** _____________________________ **Relationship to minor:** ____________ **DOB:** __________ **DL #** _______________

**Telephone #:** ____________________ **Address (*if different from above*):** ____________________________________

**PLEASE CHECK IF YOU HAVE OR HAVE HAD ANY OF THE FOLLOWING:**

◯ Cold sores/Herpes ◯ Hepatitis ◯ Photosensitive Disorder ◯ Diabetes ◯ Sensitive to Anesthetic ◯ Lupus ◯ Hypertension

◯ Heart Problems ◯ Autoimmune Illness ◯ Irregular Menses ◯ Menopause ◯ Hysterectomy ◯ Hives ◯ Keliods

**PAST SURGICAL HISTORY:** ______________________________________________________________

**MEDICATIONS:** ______________________________________________________________________

**ALLERGIES: YES OR NO** ***if yes, please explain***

**COSMETIC SURGERY:**

________________________________________________________________________________

**Have you ever used Retin-A? Yes or No If yes, what strength?**

**Have you ever used Hydroquinone (Skin Lightener)? Yes or No**

**Have you ever used Accutane? Yes or No If yes, when?**

**If you answer yes to the following please explain**

**Skin Cancer Yes or No Use of Acne Products/Drugs Yes or No Chemical Peels Yes or No**

**Hypersensitivity to Skin Products Yes or No Laser skin resurfacing Yes or No Skin Infections Yes or No**

**PRINT NAME:** ____________________________ **SIGNATURE:** ____________________________________
**DATE:** ____/____/_____