Registration Form

NEW PATIENT ☐ UPDATE ☐ DATE: _____

NAME OF PATIENT_____

ADDRESS_____ CITY/STATE_____ ZIP_____

HOME PHONE_____WORK_____CELL_____

EMAIL ADDRESS_____DATE OF BIRTH_____AGE_____

HOW DID YOU HEAR ABOUT US? _____

OCCUPATION _____

HAS PATIENT EVER BEEN SEEN BY ONE OF OUR PHYSICIANS? YES/NO ☐☐

WHICH ONE? BUHRER____ SPITTLER____

WHO IS YOUR PRIMARY CARE PHYSICIAN (PCP)?_____

PLEASE ANSWER THE FOLLOWING QUESTIONS AS THEY APPLY TO YOU:

ARE YOU ALLERGIC TO ANY MEDICATIONS?_____

DO YOU HAVE ANY SKIN ALLERGIES (LATEX, SULFIDES, ETC.)?_____

DO YOU SMOKE?_____

WHAT MEDICATIONS DO YOU TAKE?_____

DO YOU HAVE ANY MEDICAL PROBLEMS?_____

ARE YOU PRONE TO COLD SORES?_____

HOW WOULD YOU LIKE TO IMPROVE YOUR SKIN?_____

_____

LIST ALL THE SKIN CARE PRODUCTS THAT YOU USE (RETIN-A, ETC.)_____

_____

DO YOU WAX/USE DEPILATORIES?_____

DO YOU HAVE ANY UNWANTED FACIAL HAIR?_____

DO YOU USE SUNSCREEN? IF SO, WHAT KIND?_____

SKIN TYPE: Check one

☐ ALWAYS SUNBURNS, CAN NEVER TAN
☐ USUALLY SUNBURNS, CAN TAN SLIGHTLY W/DIFFICULTY
☐ SOMETIMES SUNBURNS, CAN TAN EASILY AND QUICKLY
☐ RARELY BURNS, CAN TAN EASILY AND QUICKLY
☐ NATURALLY BROWN SKIN, CAN TAN EASILY AND QUICKLY
☐ NATURALLY BLACK SKIN