# Client Registration Form

Location:

*Name* ______________________ *Birth Date* ______________________

*Address* ______________________ *City* ____________ *State* ____________ *Zip* ________
street

*E-Mail Address* ______________________

*Home Phone#* ____________ *Work Phone#* ____________ *Cell Phone#* ____________

How did you hear about us? ______________________

Check if you ever had or have been treated for any of the following conditions:

- ❑ Acne
- ❑ Allergies
  - ❑ Aspirin ❑ Latex ❑ Other ______________________
- ❑ Cold Sores or Fever Blisters
- ❑ Lupus or other Autoimmune disorder
- ❑ HIV
- ❑ Psoriasis
- ❑ Rosacea
- ❑ Tuberculosis
- ❑ Other inflammatory skin disease? ______________________

| | | |
|---|---|---|
| Are you on hormone replacement therapy? | ❑ Yes | ❑ No |
| Are you currently pregnant or nursing? | ❑ Yes | ❑ No |
| Are you currently using; Renova, Retin A or other Retinol products? | ❑ Yes | ❑ No |
| Are you currently on Accutane or Differin therapy? | ❑ Yes | ❑ No |
| Have you had any of the following in the last 7 days: Restylane® or collagen injection, Botox® injection, chemical peel or laser procedure? | ❑ Yes | ❑ No |
| Do you wear contact lenses? | ❑ Yes | ❑ No |

Medications you are currently taking: ______________________

______________________

____________ ______________________

Date: Signature of Patient or (Parent/Guardian)