



Today's date: _____

COSMETIC REGISTRATION FORM

(Please Print)

PATIENT INFORMATION

Patient's last name:		First:	M. I.:	Marital status (circle one):	
				Minor / Single / Mar / Sep / Div / Wid / Partnered / for: yrs	
Email address (please provide only if it's OK to email you appointment reminders):				Birthdate:	Age:
				/ /	Sex:
					<input type="checkbox"/> M <input type="checkbox"/> F
Address:		Home phone no.:		Cell phone no.:	
		()		() <input type="checkbox"/> OK to text	
City:		State:		ZIP Code:	
				Social Security no.:	
Occupation:		Employer/School:		Employer/School phone no.:	
				()	
Employer's Address:		City:		State:	
				ZIP Code:	

You first found out about our office from (check all that apply): Referred by another medical office or provider Insurance Plan
 Radio Website/Online Yellow Pages Saw our building or sign Postcard Newsletter Chamber of Commerce
 Another patient/word of mouth Other:

How did you get our phone number? Phone book Internet Other:

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Cell/home phone no.:	Work phone no.:
		()	()

PARENTS OF MINOR

Mother's last name:	First:	M. I.:	Father's last name:	First:	M. I.:

WHAT ARE YOUR CONCERNS?

Please check any cosmetic concerns you'd like to address: Cellulite Fat bulges Wrinkles Brown spots, freckles, uneven skin tone
 Redness/Rosacea Acne Scars Dry skin Broken capillaries Unwanted hair Skin care regimen Makeup
 Other:

BRILLIANT DISTINCTIONS

Are you enrolled in the Brilliant Distinctions Program? Yes No If yes, what email address did you use: