COSMETIC REGISTRATION FORM

TODAY'S DATE ____________________

PATIENT INFORMATION

Patient's Last Name:	First:	M.I.	Marital Status (Circle One): Minor / Single / Married / Separated / Divorced / Partnered / For: yrs

Email Address (Please provide only if it's OK to email you appointment reminders):	Birthdate:	Age:	Sex: ☐ Male ☐ Female

Address:	Home phone number: ( )	Cell phone number: ( ) ☐ OK to text

City:	State:	ZIP Code:	Social Security Number:

Occupation:	Employer / School:	Employer / School Phone Number:

Employer's Address:	City:	State:	ZIP Code:

Selected our office the first time because / Referred to office by (Check all that apply):

☐ Another Medical Office or Provider ☐ Insurance Plan ☐ Website ☐ Yellow Pages ☐ Newspaper
☐ Radio Station: ☐ TV Ad ☐ Live or work nearby ☐ Saw your building or sign
☐ Columbia Basin Racquet Club Ad ☐ Postcard ☐ Another Patient/Work of Mouth ☐ Chamber of Commerce
☐ Other:

IN CASE OF EMERGENCY

Name of local friend or relative (not living at the same address):	Relationship to patient:	Cell/Home phone number: ( )	Work phone number: ( )

PARENTS OF MINOR

MOTHER			FATHER		
Last Name:	First Name:	Middle Initial:	Last Name:	First Name:	Middle Initial:

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: