
Patient Registration

Name: _____ Date: _____
(Last) (First) (Middle Initial)

Address: _____
(Street & Apt. #) (City) (State) (Zip Code)

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Any Restrictions on Contacting You? YES _____ NO _____ Restrictions: _____

E-Mail Address: _____ Birthdate: _____ Age: _____ Gender: _____

Employer: _____ SS#: _____

Marital Status: Married _____ Single _____ Divorced _____ Widowed _____ Name of Spouse: _____

How did you hear about us?

Another Patient/Friend/Family Member (name): _____ May we thank them? YES NO

Newspaper (which one?) Tampa Tribune St. Pete Times Other _____

Patients First Family Medicine

Physician Referral (name) _____

Internet (which site?) _____

Mail/ Postcard _____

Magazine (which one?) _____

Drive by / Walk-in

Telephone Book

Other: _____

Emergency Information: In case of emergency, local friend or relative to be notified (not living at the same address):

Name: _____ Relationship to Patient: _____

Home Phone: _____ Work Phone: _____

Please check each of the services/treatments for which you want information:

Facials Cellulite Treatment Intense Pulsed Light (IPL)

Fraxel Resurfacing Sapphire 3 Photo abrasion Permanent Makeup

Botox Laser Hair Removal Restylane

Other: _____

Please list medications and supplements you are presently taking (include over the counter): _____

Please list all known allergies: _____

Have you ever had a cold sore or fever blister? YES NO

Are you pregnant or breast feeding? (females) YES NO

OFFICE POLICIES: The timeliness of treatment is important for you to achieve optimal results. We accommodate patient schedules as best we can. In consideration of this and our other patients, this office requires a **24 business hours notice for cancellation of an appointment.** This notice provides time for us to work other patients into the schedule.

Packages must be pre-paid in full at the time of scheduling your first treatment. No refunds will be given after any service or procedure has been initiated. Payment for individual (non-package) services is due at the time treatment is rendered. We accept, cash, checks, MasterCard, Visa and Care Credit.

AGREEMENT: I, (print name) _____, have read and understand the cancellation policy and terms and conditions of my financial obligation and agree to honor the office policies outlined above.

Patient Signature: _____ Date: _____