



New Patient Registration Form

Please fill in the following and when complete, click on the "submit form" button in the upper R corner of the form.

Full name:

Date of birth:

Address:

City:

State:

Zip:

Employer:

Occupation:

Contact Information: Please check the method you prefer us to use to contact you when needed (we identify ourselves as "Skinspirations"):

Cell phone:

Home phone:

Work phone:

SMS Text:

Email address (we email monthly newsletters that include specials & promotions) (personal preferred since company email filters may block) (we do not share your email address):

How did you hear about us? Check all that apply:

Referred by:

Internet search for:

St. Petersburg Magazine

Feather Sound News

South Tampa News

Liquid Facelift website

Destination St. Petersburg magazine

Facebook

Company website, name of company:

Twitter

Other:

What is your primary interest for visiting us?

Medical History

Allergies (if yes, please list medication & type of reaction):

List any medications that you take including aspirin (not vitamins or supplements):

Please check off any medical conditions that you have been treated for:

Cold Sores	Coronary artery disease	Cardiac arrhythmia, type:		
High Blood Pressure	Anxiety	Asthma	Stroke or TIA	Diabetes
Seizures	Rheumatoid arthritis	HIV	Depression	Multiple Sclerosis
Cancer, type:		Mitral valve prolapse		Lupus
Thyroid Disease, type:		Hepatitis, type:		
Prosthetic heart valve		Bleeding Disorder type:		
Drug or alcohol addiction, type:				

List any other medical conditions you've been treated for not listed above:

Please list any previous surgeries:

Do you smoke or have you smoked in the last 6 months?

No

Yes, on average I smoke cigarettes a day.

I quit months years ago & vow never to do it again.

Please check whether or not you have ever filed a lawsuit or complaint with a state-regulating agency against a physician? No Yes

Past Cosmetic Medical History

Please check any of the following procedures you've had performed in the past & describe any problems if you experienced them:

Microdermabrasion Problem:

Botox, Date of last treatment: Problem:

Chemical peels type: Problem:

Injectable fillers, type, month and year: Problem:

Intense Pulsed Light (IPL) Problem:

Laser Skin Resurfacing (involving removal of skin layers), Type:

Problem:

Skin Tightening, Type: Problem:

Laser Vein Reduction, when: Problem:

Sclerotherapy, when: Problem:

Laser hair removal, area: Problem:

Other Types of Laser Treatments: type:

Problem:

Liposuction, area: Problem:

Other: Problem:

Cosmetic Interest Questionnaire

Please check off any of the following topics you are interested in even if they are not the primary reason for your consultation:

Poor skin texture Blackheads, oily skin, or large pores Sun damage
Microdermabrasion Blotchy pigmentation, spots or brown patches
Chemical peels Rosacea or general facial redness Under eye circles
Professionally designed skin care plan Advice on professional skin products
Professional makeup consultation Customized facials specific to your skin
Lip, cheek or chin enhancement Wrinkles or unwanted lines
Botox Nonsurgical rhinoplasty for a nasal bump or asymmetric nose
"Liquid Facelift" Loose or sagging skin, area:
Injectable fillers (Juvederm, Restylane, Sculptra, Artefill, Radiesse, etc.)
Vein reduction, area: Spot fat reduction, area:
Cellulite Unwanted dark hair Scar Improvement, area:
Tattoo removal, color/s:

Thank you for taking the time to complete this information. When you're done please click on "submit" in the upper right hand corner of the form. We look forward to meeting you soon.

Sincerely,

Dr. Cynthia Elliott & the staff of Skinspirations

727.571.1923