



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 provide us with at least 2 of the following contact numbers in case of last minute schedule changes & check off the number that is your 1st choice for us to use when needed (we identify ourselves as "Skinspirations"):

Cell phone:

Home phone:

Work phone:

Text, name of cell provider:

Email address for appointment confirmations & monthly newsletters that include articles, events & promotions (personal preferred since company email filters often block outside emails). We do not ever share our email addresses.

Email address:

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

Referred by:

Internet search for:

Destination St. Petersburg Magazine

St. Petersburg Magazine

Feather Sound News

Liquid Facelift website

Facebook

Twitter

Foursquare

Courtside Grill

Company website, name of company:

Other:

What is your primary interest that you'd like to address during your visit?

Medical History

Please list any allergies:

I have no known allergies

Please list any medications that you're currently taking including aspirin (no need to list vitamins or supplements):

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

Cold sores	Asthma	Bleeding disorder, type:
High blood pressure	Diabetes	Cancer, type:
Depression	Multiple Sclerosis	Heart disease, type:
Anxiety	Hypothyroid	Hyperthyroid
Hepatitis, type:	Rheumatoid arthritis	Stroke or TIA
Drug or alcohol addiction, type:		Arrhythmia, type:
Autoimmune disease, type:		Mitral valve prolapse
Prosthetic heart valve	Connective tissue disease, type	
Seizures, type:		

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

Please list any surgeries that you've had:

Do you smoke (cigarettes) 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 treatments you've had previously.

Accutane, date: _____ Microdermabrasion _____
Chemical peels type: _____ Dermaplaning _____
Intense Pulsed Light (IPL) _____ Medical facials, type: _____
Botox, approximate date of last treatment: _____
Injectable fillers, type & approximate date: _____
Laser Skin Resurfacing, laser name if known: _____
Skin Tightening, device name if known: _____
Laser vein reduction or sclerotherapy _____ Laser hair removal, area: _____
Other Types of Laser treatments, types: _____
Liposuction, area: _____ Other: _____

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	
Medical grade facials customized to your skin type	Blotchy pigment	Brown spots	
Wrinkles or lines	Under-eye circles	"Liquid Facelift"	Acne
Botox or Dysport	Chemical peels	Microdermabrasion	
Loose or sagging skin	Advice on professional skin products	Dermal fillers	
Customized plan combining in-office treatments & home skincare	Cellulite		
Smooth out a nasal bump or asymmetric nose	Tattoo	Makeup consultation	
Vein reduction, area: _____	Spot fat reduction, area: _____		
Scar improvement, area: _____	Laser hair reduction, area/s: _____		
Other: _____			

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 or print the completed form from your printer and bring it with you. We look forward to meeting you!

Sincerely,

Dr. Cynthia Elliott & the staff of Skinspirations

727.571.1923