

**Advanced Dermatology and Aesthetic Center  
New Patient Information**

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
Street Address \_\_\_\_\_ City \_\_\_\_\_  
State \_\_\_\_\_ Zip Code \_\_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_\_ SS# \_\_\_\_\_  
Referred By Dr. \_\_\_\_\_  
Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_  
Employer \_\_\_\_\_  
Employer's Address \_\_\_\_\_

**Parent/Guardian/Spouse Information**

Name \_\_\_\_\_ SS# \_\_\_\_\_  
Street Address \_\_\_\_\_  
Mailing Address \_\_\_\_\_  
Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_  
Employer \_\_\_\_\_  
Employer's Address \_\_\_\_\_  
Next of Kin \_\_\_\_\_ Add. \_\_\_\_\_ Phone \_\_\_\_\_

**Payment is required for all services at the time they are rendered.** We accept payment in the form of cash, check, and credit card. Your signature below signifies your understanding and willingness to comply with this policy.

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

**COSMETIC INTEREST QUESTIONNAIRE**

Health Issues of interest to you (please check all that apply):

- |  |  |
|--|--|
| <input type="checkbox"/> BOTOX Cosmetic (Botulinum Toxin Type A) | <input type="checkbox"/> Skin care advice      |
| <input type="checkbox"/> AHA and Glycolic peels                  | <input type="checkbox"/> Skin care products    |
| <input type="checkbox"/> Acne                                    | <input type="checkbox"/> Spider veins          |
| <input type="checkbox"/> Removing facial veins                   | <input type="checkbox"/> Laser treatments      |
| <input type="checkbox"/> Chemical peels                          | <input type="checkbox"/> Liver Spots/age spots |
| <input type="checkbox"/> Other, please specify: _____            | <input type="checkbox"/> Hair Removal          |

