

Aesthetic Registration Form



Today's Date:	Primary Care Physician:
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Pharmacy Information

Pharmacy Name	Phone
Street	City
State	Zip

Patient Information

Last Name	First Name
Prefix <input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Miss <input type="checkbox"/> Ms.	Is This Your Legal Name? <input type="checkbox"/> Yes <input type="checkbox"/> No If not, what is your legal name?
Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Age
Date of Birth / /	Cell Phone

How Did You Hear About Us (Please Check One Box)

<input type="checkbox"/> Doctor	<input type="checkbox"/> Insurance Plan	<input type="checkbox"/> Hospital	<input type="checkbox"/> Friend/Family	<input type="checkbox"/> Close To Work / Home
<input type="checkbox"/> Other	<input type="checkbox"/> Yellow Pages	<input type="checkbox"/> Instagram	<input type="checkbox"/> Facebook	<input type="checkbox"/> Google Search

Other Family Members Seen Here

Email Address _____ @ _____ .com

Home Address

Street	City
State	Zip

In Case Of Emergency

Name of Local Friend Or Relative (not living at same address)	Relationship to Patient
Home Phone	Work Phone

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize The Kaga Institute to release any information required to process my claims.

Patient/Guardian Signature

Today's Date

Have You Ever Been Diagnosed With Any Of The Following					<input type="checkbox"/> No Diagnoses
Heart murmur	<input type="checkbox"/> Yes <input type="checkbox"/> No	Circulatory problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Phlebitis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Blepharoplasty	<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you wear contacts?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Skin cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No
Fainting/Dizzy Spells	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hyper-Pigmentation	<input type="checkbox"/> Yes <input type="checkbox"/> No	Allergies	<input type="checkbox"/> Yes <input type="checkbox"/> No
Keloids	<input type="checkbox"/> Yes <input type="checkbox"/> No	High blood pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No
Thyroid disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Bleeding disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hepatitis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Herpes simplex	<input type="checkbox"/> Yes <input type="checkbox"/> No	Chemotherapy/radiation	<input type="checkbox"/> Yes <input type="checkbox"/> No	Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No
Tumors/Growths	<input type="checkbox"/> Yes <input type="checkbox"/> No	Corneal abrasions	<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you smoke?	<input type="checkbox"/> Yes <input type="checkbox"/> No

List all medications you are currently taking			<input type="checkbox"/> No Medications
Medication Name	Dose	Frequency Taken	
Medication Name	Dose	Frequency Taken	
Medication Name	Dose	Frequency Taken	

List any drug, makeup, food, or skin allergies		<input type="checkbox"/> No Allergies
Allergic To	Allergic Reaction	
Allergic To	Allergic Reaction	

General Questions (Part 1)	
Have you been on Accutane in the past nine months?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Laser resurfacing in the past year?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Are you using, or have ever used Retin-A?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If so, when was your last application?	
Are you pregnant?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If so, how far along are you?	
Have you ever been tested for HIV?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If so, results?	
Do you have an immune disorder that would impair your healing process?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Are you prone to general herpes breakouts? Cold sores?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have any venereal diseases?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If so, what are they?	
What is your natural hair color?	<input type="checkbox"/> Black <input type="checkbox"/> Brown <input type="checkbox"/> Blonde <input type="checkbox"/> Red
What is your natural eye color?	<input type="checkbox"/> Brown <input type="checkbox"/> Hazel <input type="checkbox"/> Green <input type="checkbox"/> Blue

General Questions (Part 2)

Have you recently undergone a skin peel?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If so, how long ago?	
When did you last tan your skin?	
When were you last exposed to sun, tanning beds, creams?	
Have you ever had sclerotherapy?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If so, how long ago?	
When a scar appears on your skin, is it significantly dark in color?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Are you currently taking any birth control pills?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Are you taking oral or injectable steroids?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Going back three generations what is your family ancestry?	

Skin Type

Fitzpatrick Skin Test (Check the one that describes your skin)

Type 1: always burns, never tans. Red hair, blonde hair, light eyes.

Type 2: somewhat tans, mostly burns.

Type 3: sometimes burns, mostly tans, also known as olive complexion.

Type 4: rarely burns, almost always tans, also known as olive complexion.

Type 5: moderately pigmented (Indian, Persian, light African-American).

Type 6: African-American.

Skin Care Regimen (Specify products you are currently using)

Cleanser	Exfoliant	Treatment	Hydration

Patient/Guardian Signature

_____/_____/_____
Today's Date