Patient Information Sheet

Name:______________________________ D.O.B.:____________

Address:____

City:____________________ State:____________ ZipCode:__________

Home Phone:______________________

Work Phone: ______________________

Cell Phone: ______________________

E-Mail Address: ______________________________________

Emergency Contact:____________________________________
(Name & phone number)

Who May I Thank For The Referral:____________________________

Please Answer The Following Questions:

1.	Do you wear contact lenses?	YES	NO
2.	Have you used/taken cortisone/steroids in the last 6 months?	YES	NO
3.	Do you have a history of cold sores? If yes, all lip procedures will require a prescription for an anti viral medication.	YES	NO
4.	Are you currently taking Accutane or have been on, in the past 6 months?	YES	NO
5.	Are you using a topical cream such as Retin-A,on a regular basis?	YES	NO
6.	Are you a smoker?	YES	NO

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