



DR. MONICA MCCRARY  
MINDY HUCKS, RN

**COSMETIC**  
PATIENT INFORMATION

Last Name: \_\_\_\_\_  
First Name: \_\_\_\_\_  
Preferred Name: \_\_\_\_\_  
Middle Name: \_\_\_\_\_ Suffix: \_\_\_\_\_  
Former Last Name: \_\_\_\_\_  
Gender: \_\_\_\_\_  
Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
Address: \_\_\_\_\_  
Address: (*Apt., Unit, etc.*): \_\_\_\_\_  
Zip Code: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_

I wish to be contacted in the following manner:

Home Phone: ( \_\_\_\_ ) \_\_\_\_\_  
 Mobile Phone: ( \_\_\_\_ ) \_\_\_\_\_  
 Work Phone: ( \_\_\_\_ ) \_\_\_\_\_  
Extension: \_\_\_\_\_

*\* Cosmetic treatments are cash pay services. Insurance information is only used if a future medical visit is needed.*

**Primary Insurance**

Insurance Company: \_\_\_\_\_  
Patient's relationship to Policy Holder:  
 Self  Spouse  Child  Other \_\_\_\_\_  
Policy Holder Last Name: \_\_\_\_\_  
Policy Holder First Name: \_\_\_\_\_  
Policy Holder Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
Policy Holder Gender: \_\_\_\_\_

**Secondary Insurance**

Insurance Company: \_\_\_\_\_  
Patient's relationship to Policy Holder:  
 Self  Spouse  Child  Other \_\_\_\_\_  
Policy Holder Last Name: \_\_\_\_\_  
Policy Holder First Name: \_\_\_\_\_  
Policy Holder Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
Policy Holder Gender: \_\_\_\_\_

EMERGENCY CONTACT: Name: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Phone Number: \_\_\_\_\_

ALLERGIES: Do you have any known allergies (including medications, foods, latex, bandage tape)?  YES  NO  
If YES, please provide more detail: \_\_\_\_\_

When contacting me (please check one): <input type="checkbox"/> Leave a message with detailed information. <input type="checkbox"/> Leave a message with a call back number only <input type="checkbox"/> Do NOT leave a message.	Patient's Preferred Phone#:  Patient's Email Address:
--	---

Pharmacy Name: \_\_\_\_\_ Phone:( \_\_\_\_ ) \_\_\_\_\_  
Street: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

If you are a <b>FEMALE</b> patient ( <i>otherwise leave blank</i> ).	
Are you pregnant or trying to become pregnant?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Are you nursing or breastfeeding?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Do you have PCOS (polycystic ovarian disorder)?	<input type="checkbox"/> YES <input type="checkbox"/> NO

Confidential and Proprietary



DR. MONICA MCCRARY  
MINDY HUCKS, RN

**PAST MEDICAL HISTORY:**

Which of the following medical conditions or treatments have you ever had? *Check all that apply.*

<input type="checkbox"/> HIV/AIDS	<input type="checkbox"/> Hepatitis B	<input type="checkbox"/> Hepatitis C	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Biologic Therapy/ Chemotherapy	<input type="checkbox"/> Organ or Bone Marrow Transplantation	<input type="checkbox"/> Radiation Treatment	<input type="checkbox"/> Cancer	If YES, which types: _____
<input type="checkbox"/> Heat Urticaria	<input type="checkbox"/> Auto Immune Disorder	<input type="checkbox"/> Blood Disorders	<input type="checkbox"/> Infections or Open Wounds	<input type="checkbox"/> Skin Photosensitivity Disorder
<input type="checkbox"/> Diseases Affecting Collagen	<input type="checkbox"/> Cold Sores	<input type="checkbox"/> Keloid Scarring	<input type="checkbox"/> Light Induced Seizures	<input type="checkbox"/> Permanent Makeup or Tattoos
<input type="checkbox"/> Accutane Use If YES, last dose: _____		<input type="checkbox"/> Blood Thinners If YES, please specify type and last usage: _____		
Please list any other known medical conditions, surgeries, and hospitalizations:  _____				

**SKIN CONDITION HISTORY:**

Do you use tanning beds?	<input type="checkbox"/> YES	<input type="checkbox"/> No
Do you use self-tanning cream?	<input type="checkbox"/> YES	<input type="checkbox"/> No
Do you use Retin-A?	<input type="checkbox"/> YES	<input type="checkbox"/> No
If yes, when was your last use? _____		
When was the last time you had sun exposure longer than 30 minutes without Sunscreen? _____		
Have you had the following?	Please include location and date of last use/application/treatment	
<input type="checkbox"/> Botox		
<input type="checkbox"/> Fillers		
<input type="checkbox"/> Cosmetic Laser Treatments		
<input type="checkbox"/> Hair Removal		

Patient/Legal Guardian's Signature:	(Office use only) Entered into EMA by:
-------------------------------------	--

Confidential and Proprietary



DR. MONICA MCCRARY  
MINDY HUCKS, RN

**SKIN TYPING WORKSHEET**

Client Name: \_\_\_\_\_

Date: \_\_\_\_\_

Score: _____		0	1	2	3	4
	What is your eye color?	Light blue or gray	Blue or green	Hazel, Light brown	Dark brown	Brownish black
	What is the natural color of your hair?	Red, Sandy red	Blonde	Dark blonde, chestnut, Brown	Dark brown	Black
	What is the color of your skin (unexposed areas)?	Reddish	Very pale	Pale with beige tint	Light brown	Dark brown
	Do you have freckles on sun-exposed areas?	Many	Several	Few	Incidental	None
	What happens when you stay in the sun too long?	Painful redness, blistering, peeling	Blistering, followed by peeling	Burns, sometimes followed by peeling	Rarely bums	Never had bums
	To what degree do you turn brown?	Hardly any or not at all	Light tan	Reasonable tan	Tan very easily	Turn dark brown quickly
	Do you turn brown several hours after sun exposure?	Never	Seldom	Sometimes	Often	Always
	How does your face respond to the sun?	Very sensitive	Sensitive	Normal	Very resistant	Never had a problem
	When did you last expose yourself to the sun, tanning bed or self-tanning creams?	More than 3 months ago	2-3 months ago	1-2 months ago	Less than 1 month ago	Less than 2 weeks ago
	How often is the area you want to have treated exposed to the sun?	Never	Hardly ever	Sometimes	Often	Always

Add above for Total score:	Match your total score with the corresponding Skin Type.	Fitzpatrick Skin Type:
	0 – 7	I
	8 – 16	II
	17 – 25	III
	26 – 30	IV
	Over 30	V - VI