SKIN
PHARM
cosmetic dermatology

Patient Information

Name: _____

DOB: _____ Gender: Male / Female Occupation: _____

* How did you hear about us? _____

Contact Information

Mobile Phone: _____

Email: _____

Address: _____ City/State:_____ Zip Code:_____

Emergency Contact

Name:_____ Relationship: _____ Phone: _____

Prescriptions

Preferred Pharmacy: _____ Zip Code: _____

Allergies and Medications

Do you have any drug allergies? YES / NO

If so, please list here _____

Are you currently taking any medications? YES / NO

If so, please list here _____

Past Medical History

Do you have any ongoing medical problems? YES / NO

If so, please list here _____

Are you currently pregnant? YES / NO Are you currently breastfeeding? YES / NO

SKIN
PHARM
boutique practice

PATIENT FINANCIAL RESPONSIBILITY ACKNOWLEDGEMENT

At this time, Skin Pharm, LLC does not accept insurance for services. This means all cosmetic and medical visits are cash pay and 100% responsibility of the patient. Please sign & date below to acknowledge this statement. If you have any questions about the pricing of your services today, please feel free to inquire before your appointment begins.

Print Name:_____ **Sign Name**: _____ **Date**: _____

CANCELLATION POLICY / FEE AGREEMENT

Your scheduled appointment is reserved exclusively for you. Should you need to cancel or reschedule your appointment, please notify us at least 24 hours in advance to avoid a charge. *There will be a fee of $50 for office visits and a fee of $150 for procedures (i.e. injections, lasers, peels) that are not cancelled with proper notice.* Please sign & date below to acknowledge this cancellation policy and agree to being responsible for this payment if your appointment is missed without the 24-hour notice.

Print Name:_____ **Sign Name**: _____ **Date**: _____

CREDIT CARD ON FILE AUTHORIZATION

I understand that I am financially responsible for the purpose(s) stated on this policy and authorize Skin Pharm, LLC to run my credit card for all purpose(s) stated on this policy.

Name on Card:_____ **Sign Name**: _____ **Date**: _____

CONTACT PERMISSIONS

Please circle the appropriate answer then sign and date below to grant these contact permissions Skin Pharm, LLC.

Skin Pharm, LLC has permission to leave a message on my voicemail at the number(s) listed above.
YES / NO

Skin Pharm, LLC has permission to send me TEXT messages regarding appointment reminders to the cell phone number listed above.
YES / NO

Print Name:_____ **Sign Name**: _____ **Date**: _____