KRAUSS DERMATOLOGY
781.416.3500
1 Washington Street Suite 401
Wellesley Hills, MA, 02481

Patient name: _____ Today's date: _____
DOB: _____ Home Address: _____
City: _____ State: _____ Zip: _____

Home Telephone #: _____ Mobile #: _____ Work #: _____
Are we authorized to leave a voicemail? Yes _____ No _____

Email address: _____
May we communication with you about your services via email? Yes _____ No _____
May we send you notifications of specials, promotions or events via email? Yes _____ No _____
May we send you an email appointment reminder? Yes _____ No _____

How were you referred to our practice?
PCP Name: _____Other MD: _____
Friend: _____Website: _____
Advertisement or Promotion: _____ Other: _____

What are you here to discuss: _____

Do you have a specific treatment in mind? _____

Have you had any previous cosmetic services? _____

If so, were you satisfied with the results? _____ What & when was the last treatment? _____
_____

Do you have any upcoming special events to plan for? _____
Are you enrolled in VIP reward programs, Brilliant Distinctions with Allergan® or Aspire with Galderma®?
_____

Please X any areas of concern: (please check all that apply)

	Crow's Feet/Wrinkles		Sagging skin, sunken cheeks		Double chin
	Furrows between the brows		Drooping of jowls/jawline		Unwanted fat on body
	Forehead Lines		Rough or tired-looking skin		Surgical scar improvement
	Wrinkles between mouth & nose		Freckles / Brown Spots		Underarm sweating
	Lines around the mouth		Age Spots / Raised Moles		Acne or acne scars
	Excess Hair		Mask of pregnancy		Blood vessels on face

Medical History

	Yes	No	Explain
Any allergies to medication?			
Do you have any other allergies:			
Do you smoke? How often?			
Have you been hospitalized, had surgery, or had any chronic illnesses within 1 year?			
Do you have a bleeding disorder?			
Do you bruise easily?			
Do you take any prescription medications?			Please list:
Do you take any over the counter (OTC) medications regularly or recently? ie. Aspirin/ Ibuprofen/ Motrin/ Advil			Please list:
Have you experienced any adverse reactions to previous cosmetic procedures?			
Have you experienced any rashes, reactions to products used on the skin?			

I attest that the above information is accurate.

_____ _____

Patient signature Date

I have been able to review the Krauss Dermatology Notice of Privacy Practices (available in our office or on our website. This notice provides information about how Krauss Dermatology may use and disclose my protected health information, what its legal duties are regarding my protected health information, and what my rights are regarding my protected health information, and I how I can file a complaint about these privacy practices. I understand that if I have additional concerns, I may ask the HIPAA compliance officer at Krauss Dermatology for clarification.

Signature: _____ Date: _____