Harold J. Kaplan, M.D.
Aesthetic Services Patient Registration

☐ Miss ☐ Mrs. ☐ Ms. ☐ Mr. ☐ Dr.	Today's Date:
Name:	Chart Number:
Address:	
City: State: Zip:	Birth Date: Age:

Home Phone: ( ) Ext:	Cell Phone: ( )
Work Phone: ( ) Ext:	E-Mail:
Best Phone(s) to call: ☐ Home ☐ Work ☐ Cell ☐ No preference	
Best Time(s) to reach you:	

HOW DID YOU FIND OUT ABOUT OUR AESTHETIC SERVICES?

☐ Friend/Family_____ ☐ Physician _____
☐ Newspaper_____ ☐ Dr. Kaplan ☐ Dr. Kaplan's Website
☐Yellow Pages ☐ Other_____

MEDICAL HISTORY:

ALLERGIES/SENSITIVITIES:

☐ Vitamin C ☐ Aspirin ☐ Retin A ☐ Bleaching Products ☐ Copper ☐ Aloe Vera
☐ Alpha Hydroxy Acids ☐ Vitamin E ☐ Latex Other:

The following medical conditions MAY be contraindicated for certain aesthetic services. Please indicate which, if any, apply to you:

☐ I am pregnant	☐ I have a history of cold sores	☐ I have/ had Hepatitis or other viral disease
☐ I am lactating	☐ I have uncontrollable diabetes	
☐ I have eczema / dermatitis	☐ I am taking oral blood thinners	☐ I have received radiation/ chemotherapy _____
☐ I have Rosacea	☐ I have skin cancer	

Accutane: ☐ Never taken **Last Dose taken**: ☐ Within the last 12 mos. ☐ More than 1 year ago

SKIN CARE HISTORY:

I regularly use topical products containing: ☐ Retin A / Retinol ☐ Alpha Hydroxy Acid
☐ SPF 30 sunscreen ☐ Vitamin C ☐ Antioxidants ☐ Skin Lighteners ☐ Acne Medication

Treatment history includes: ☐Microdermabrasion ☐Light chemical peels ☐Laser resurfacing

MY CONCERN(S) INCLUDE: ☐ Skin texture ☐ Hyper/Hypo Pigmentation ☐ Sun Damage
☐ Acne ☐ Pore size ☐ Scars ☐ Other:

EMERGENCY CONTACT: Relationship:

☐ Ms. ☐ Mr. First name:	Last name:
Daytime Phone: ( )	Cell Phone: ( )