Date: _____

Gerald Pierone, Jr., MD and Greer Hanson, ARNP

New Patient Information – Facial

(Please Print)

FIRST Name_____ LAST Name_____ MI____

Mailing Address: _____

City_____ State_____ Zip_____ Seasonal / Year Round

Home Phone No. (____) _____ Cell phone. (____) _____

Birthdate _____ Age: _____ May we follow up with you on your treatment? Y/N

Emergency Contact Name and Phone No. _____

E-Mail Address_____

How may we confirm your appointment? Email Text Message Phone Call
(Please Circle)
May we add you to our e-newsletter list for special information and offers? Y / N

How did you hear about us? Friend / Internet / Event / Social Media / Newspaper / TV
(Please Circle)
Reason for your visit today? _____

Medication (include vitamins and supplements) _____

_____

Medical Conditions: _____

_____

Allergies _____

Any previous aesthetic procedures or surgeries? List procedure and dates

_____

_____

_____

_____

Date: _____

Name: _____

In which of the following areas have you received cosmetic procedures? (Circle Y or N)

Forehead	Yes	No	Nose/ nose area	Yes	No
Eyebrows and between eyes	Yes	No	Lips	Yes	No
Temples	Yes	No	Chin	Yes	No
Crow's feet	Yes	No	Jaw line	Yes	No
Under the eyes	Yes	No	Hands	Yes	No
Cheeks	Yes	No	Neck	Yes	No

Please select your top 3 reasons for being interested in cosmetic facial treatments.

- [ ] To look younger
- [ ] To look more attractive
- [ ] To look like a celebrity
- [ ] To look my best for a major event or special occasion
- [ ] To feel good about myself
- [ ] To look better for my significant other
- [ ] To gain attention of others
- [ ] To feel more attractive for potential partners
- [ ] For professional or career related reasons
- [ ] To look less tired
- [ ] To maintain my current look
- [ ] Other

Are you interested in any of the following services?

- [ ] Laser Treatments for pigmentation and fine lines
- [ ] CoolSculpting Fat Reduction
- [ ] Exilis- Radio Frequency for skin tightening
- [ ] Ultherapy - Ultrasound procedure for skin tightening
- [ ] Dermal Fillers
- [ ] Botox/Dysport
- [ ] Non-surgical Facelift
- [ ] Microneedling/ VIVACE

Date: _____

Skincare Evaluation

Name: _____

Pick the one statement that best describes your skincare needs

( ) I want a simple, health skincare regime and/or I have sensitive skin

( ) I have early to moderate signs of aging and would like to prevent future damage

( ) I have advanced signs of aging and would like to repair my damaged skin

( ) I have mild to moderate acne blemishes I would like to control

Pick the one statement that most closely describes your skin type

( ) Dry Sensitive / Normal / Resilient (Circle One)

( ) Normal

( ) Combination

( ) Oily

Pick the one statement that describe your other skincare needs (check all that apply)

( ) Brighten and even skin tone, reduce dark spots

( ) Improve the texture of my skin and make pores look smaller

( ) Need on-the-go cleanser for the gym, vacation, etc.

( ) Help reduce the appearance of expression lines

( ) Want skin to appear lifted and firmed

( ) Need extra hydration

( ) Control excess oil on my face or T-zone

( ) Need maximum hydration for extremely dry skin

The skin around your eye and lip areas requires special care. Select the statements that apply to you (check all that apply)

( ) Diminish dark circles, reduce puffiness around the eyes

( ) Moisturize, firm, brighten and minimize fine lines and wrinkles around the eye area's delicate skin.

( ) Reduce the lines and wrinkles around my lips

What is your current skincare regimen? _____