SELECTSKINMD
SKIN CARE **Date** _____

LEGAL Name:_____ **Soc. Sec. #**_____

Date of Birth:_____ **Age:**_____ **Sex:**_____ **Marital Status:**_____

Spouse or Parents/Guardian: _____

Patient's
Mailing Address:_____ **City:**_____ **State:**_____ **Zip:**_____

Seasonal Address: _____ **City:**_____ **State:**_____ **Zip:**_____

Home Telephone:_____ **Cell Telephone:**_____

Employer:_____ **Employer Telephone:**_____

Friend or relative <u>not living with you</u> that we may contact in case of emergency (REQUIRED):

Name: _____ **Telephone:**_____

Regular Physician :_____ **City:**_____ **State:**_____

Referral Source:_____

To determine skin type, check one of the following:

TYPE	**SKIN COLOR**	**REACTION TO FIRST SUN EXPOSURE YEARLY**
_____ I	White	always burns / never tans
_____ II	White	usually burns / tans with difficulty
_____ III	White / Asian	sometimes mild burn / average tan
_____ IV	Moderate brown	rarely burns / tans with ease
_____ V	Dark brown	very rarely burns / tans very easily
_____ VI	Black	never burns

I, the undersigned, am aware that I am financially responsible for my charges in full for services and skin care products. I agree to be responsible for any legal fees and / or court costs incurred as a result of my failure to pay for services rendered.

Patient's name: (please print): _____ **Date:** _____

Patient's Signature (or that of Parent / Guardian):_____

Please note that this office is compliant and regulated by the Board of Medicine Rule Chapter 64B8-9.009, F.A.C. Effective February 17, 2000