Patient Registration

Today's Date _______________

Last Name ___________________________ First Name ____________________________ M.I. _________

Street Address ____

City __________________________________ State _____________________ Zip Code _______________

Home Phone ________________ Mobile Phone _________________Work Phone ___________________

Email ____

Date of Birth _____________________ Age _________ Sex ________ Driver's License # _______________

Name of Spouse ____

If a Minor, Name of Parent or Legal Guardian ____

Emergency Contact _______________________________ Relationship _________________________

Phone Number _________________________________

How did you hear about us? ____

___ Check if you would like to receive email updates about offers, events, and other news at TOC Eye & Face and TOC Medical Spa. Follow us on Instagram @TOCMedicalSpa for special updates, giveaways, and more!

___ I approve pre-treatment and post-treatment photos to be taken for my medical record.

___ I am comfortable with my before and after photographs to be used on TOC marketing and web based communication. I am open to further conversation with my provider.

Signature ____

Acknowledgement of Privacy Practices (Please Initial) ___________

Patient Health History

Name ____ **Date**____

Do you have or have you had any of the following:

Skin/connective tissue disorder	Eye Surgery or injury	Neurological Diseases	HIV
Bleeding disorder	Thyroid (Over/Under)	Chemotherapy/radiation	Ocular Disorders
High/Low blood pressure	Heart problems	Metabolic Disorders	Muscle Disorders
Cancer	Tumors/growths/cysts	Hepatitis	Silicone injections

Do you smoke? Yes No

Please list any drug allergies that you have: ____

Please list any major illnesses/chronic conditions: ____

Please list any major hospitalizations: ____

Please list any family history of skin cancer: ____

Please list any oral or topical medications/products you are using on a regular basis (include prescription, over the counter, vitamins, natural supplements): ____

Have you had the COVID Vaccine? Yes No If so, what is the date of your last vaccine? ____________

How much sun exposure do you get in an average week? __________ Hours

Do you use tanning booths? Yes No Do you use SPF? Yes No If yes, what SPF level? ____________

Circle all that currently apply to your skin:

Acne Pimples Broken Capillaries/area: __________________ Enlarged Pores

Are you pregnant? Yes No Are you breastfeeding? Yes No

Have you had any facial reconstructive/cosmetic surgery? Yes No

If yes, please specify: ____

Have you had any non-surgical cosmetic treatments? For example, Botox, dermal filler, laser, etc. Yes No

If yes, please specify: ____

Do you get cold sores or fever blisters? Yes No If yes, how often? __________________

In the past week have you had any facial treatment including facial waxing/electrolysis/threading/chemical peel, etc.? Yes No

Have you used any of the following? Accutane Retin A Retinoid

If using Accutane: When was your last dose?__________ If using RetinA: How long ago? ______________

Strength of RetinA: .1% .05% .025% Renova Tazorac Avage Other: __________________

Have you seen a dermatologist in the past five years? Yes No

What product(s) do you currently use? Cleanser Toner Moisturizer Scrubs Masques Sunscreen
Sunscreen Brand: ____

Cancellation/No Show Policy

Cancellations

We would like to thank you for choosing TOC Medical Spa. We value our patients and strive to provide the best care possible. Please understand that when we schedule your appointment, we are reserving time for your particular needs. We kindly ask that if you must change an appointment, please give us at least 24 hours' notice. This courtesy makes it possible for us to give your reserved time to another patient. We know that your time is valuable. When an appointment is made, a room is reserved, your records prepared, and special instruments are readied for your visit. If you are unable to keep an appointment, we ask that you cancel at least 24 hours in advance.

Missed Appointments (Non-Cancelled)

We understand that occasional missed appointments can occur for a variety of reasons. We track missed (non-cancelled) appointments. A "no show/late cancellation" is defined as missing an appointment without cancelling at least 24 hours before scheduled time. There will be a $50 charge for a missed or non-cancelled appointment.

Payment

Payment is due in full at the time of service. No exceptions.

___________________________ ___________________________ _______________
Patient Name Signature Date