ADVANCED SPECIALTY CARE

107 Newtown Road, Suite 2C, Danbury, CT 06810 (203) 791-9661 • 901 Ethan Allen Highway, Ridgefield, CT 06877 (203) 438-5080
488 Main Ave, Norwalk, CT 06850 (203) 857-9217 • 22 Old Waterbury Road, Southbury, CT 06488 (203) 262-4270 • 131 Kent Road, New Milford, CT 06776 (860) 354-0760

LEGAL First Name________________________Last Name______________________________________M.I.____

❑ Male ❑ Female Date of Birth ____/____/____ Age_____

Social Security # ___________ ________ ________________ E-mail _____________________________________

Street____ City____________________ State_____ Zip______________

Home Tel. # (____)__________________ Business Tel. # (____)______________Your Cell # ____________________

Primary Doctor____________________________________ Location (City) _______________________________

(As listed on your insurance card)

Referring Doctor____ Local Pharmacy ____________________________

Please note: $50.00 No Show fee will be charged to your credit card if no show or you do not cancel within 24 hours

In order to receive email communications from Advanced Specialty Care, such as appointment reminders and promotional specials please provide us with your email address: ____

1. How would you like to improve your skin? ____
2. Do you have any history of: Chronic Acne: ______ Chronic Skin Sensitivity: _______
   If yes please explain: ____
3. Have you been told you have skin cancer? Yes ______ No ______
4. Is there a history of skin cancer in your family? Yes _____ No _____
5. Have you ever taken aspirin specifically? (not asking about other pain relievers) Yes _____ No _____
6. Are you allergic to aspirin? Yes _____ No _____
7. Do you have any allergies? Yes _____ No _____ (this includes medicine, food, fabrics, etc…)
8. Have you been told you have diabetes? Yes_______ No______
9. Are you pregnant or lactating? Yes _____ No _____
10. Have you ever taken Accutane? Yes _____ No _____ If Yes, When? _________________________________
11. Have you been diagnosed with active MRSA? Yes _____ No _____ If Yes, When? ________________________
12. Do you have a history of shingles, herpes or cold sores? Yes _____ No _____ If Yes, how frequent? _________________
    Have the lesions been acute in the last 4 to 6 weeks? Yes _____ No ______
13. Do you currently take any oral medications, antioxidants or herbal supplements? Yes _____ No ______
    If yes, please explain: ____
14. Have you used facial waxes or depilatories in the past month? Yes _____ No _____
15. Do you have any health problems? Yes _____ No _____
    If yes, please explain: ____
16. Do you have any problem healing from a cut or burn? Yes _____ No _____
    If yes, please explain: ____
17. Have you had chemotherapy or radiation? Yes _____ No _____
    If yes, please explain: ____
18. Have you had facial peels, laser, surgery or dermabrasion? Yes _____ No _____
    If yes, please explain: ____
19. Would you like more information about Botox, Restylane or any other facial fillers? Yes ________ No_________
20. What products do you use daily for your skin care? ____
21. Do you use Retinol Creams, Retin-A, Glycolic Products or other topical preparations? Yes ____ No ____
    If yes, please explain the strength and frequency of use: ____
22. Do you use sun protection daily? Yes _____ No _____ Do you use tanning beds? Yes _____ No _____
23. Do you wear contact lenses? Yes _____ No _____
24. How did you hear about the skin care clinic? ____

_________________________________ _________________________ ____________

Patient Signature (Parent or Guardian if Minor) Parent/Guardian Date of Birth Date