DR. SHAUN PARSON
PLASTIC SURGERY
& SKIN CENTER

Registration Form
(Please print and complete all items)

PERSONAL HISTORY Today's Date: _____

Patient's Name: _____ Age: _____ Sex: _____

Address: _____ Apt/ Unit #: _____

City: _____ State: _____Zip Code: _____

Email Address: _____

Date of Birth: _____ Social Security #: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Cell Provider: _____

Pharmacy Number: _____

Marital Status: _____ Single _____ Married _____ Widowed _____ Divorced _____ Separated

Occupation: _____ Employer: _____

Spouse's Name: _____ (Okay to discuss medical info) Yes _____ No_____

Spouse's Phone: _____ Spouse's Date of Birth: _____

Nearest relative not living with you (for emergencies)

Name: _____ Relationship: _____

Okay to discuss medical info with this person Yes_____ No_____ Telephone: _____

_____Patient Signature/ Responsibility Party

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PATIENT HISTORY

Name: _____ Date: _____

How did you hear about us?

( ) Google ( ) Instagram ( ) Facebook ( ) Yelp Family/Friend:_____

Have you or any member of your family ever been treated by our physicians for any condition before this visit?

_____

_____

Things I would like to talk to the doctor about _____

_____

_____

Have other plastic surgeons been consulted? [] Yes [] No

(List Names) _____

Previous operations, including plastic surgery procedures:

Date	Age	Operation	Physician/ Hospital
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Accidents: Please list any serious type of injuries requiring emergency room treatment or hospitalization.

Date	Age	Operation	Physician/ Hospital
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Allergies to drugs or medications (please list any known) _____

_____

Do you use tobacco products? [] Yes [] No

Please list any medications you are presently taking _____

_____

Have you ever had a blood transfusion for any reason? [] Yes [] No

FEMALE MEDICAL HISTORY

Are you presently taking any female hormone medication such as premarin, estrogen or birth control pills?

[] Yes [] No

Caesarean Sections _____ Hysterectomy [] Yes [] No

Date of Last mammogram _____ Breast Implants [] Yes [] No

FAMILY HISTORY

Please check if any family member suffers from any of the illnesses listed below

[] Cancer [] Tuberculosis [] Diabetes [] Strokes [] Heart Disease [] Allergies

Relationship of family member closest to you: _____

PERSONAL HISTORY

Childhood Diseases [] Mumps [] Measles [] Diphtheria [] Rheumatic fever

[] Other _____

Adult Diseases _____

Height _____ Weight _____

The information provided is correct to the best of my knowledge._____

Patient Signature

Are you interested in learning more about any of the following?

[] Botox (wrinkle reduction)

[] Facial Fillers (Juvederm, Voluma, Restylane, Perlane)

[] Kybella

[] Sculptra

[] Medical Grade Skincare

[] Microneedling

[] Hair Restoration

[] Microneedleing w/ PRP "Vampire Facial"

[] Laser Hair Removal

[] Sclerotherapy

[] IPL/Photofacial

[] Co2

[] Non-Surgical Skin Tightening

[] Lasers

[] Chemical Peels

[] Dermaplane

Anything else you would like to learn more about that is not listed?

_____

_____

_____