



Date: \_\_\_\_\_

**Parsons Dermatology and Cosmetics  
INTAKE FORM**

Name \_\_\_\_\_ Birth date (Month/Day/Year): \_\_\_\_\_

Address: \_\_\_\_\_ Phone (Home): \_\_\_\_\_

Phone (Alternate): \_\_\_\_\_ Email address: \_\_\_\_\_

Family Doctor: \_\_\_\_\_ Referring Doctor: \_\_\_\_\_  
Do you want to join our monthly newsletter list? : Y or N

Health Card Number: \_\_\_\_\_ Pharmacy: \_\_\_\_\_

Reason for your visit today: \_\_\_\_\_

**\*AT EACH VISIT ONLY ONE CONCERN WILL BE ADDRESSED\***

Please list **ALL** medical conditions

Please list **ALL** medications

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Are you **pregnant or breastfeeding**? Yes \_\_\_\_\_ No \_\_\_\_\_

Are you on a **blood thinner**? (Aspirin, Plavix, Coumadin/Warfarin, other): Yes \_\_\_\_\_ No \_\_\_\_\_

Please list **any allergies** to medication: \_\_\_\_\_

Family History (Please circle any that apply): **Melanoma** **Eczema** **Psoriasis**

**COSMETIC SERVICES**

Did you know that Dr. Parsons provides many cosmetic services and can help with improving your overall skin health? Please let us know if you're interested in finding our more information about any of the following cosmetic concerns (Please circle):

Acne Scarring

Ageing Skin

Brown Spots

Double Chin

Dull Skin

Facial Volume Loss

Fine lines and Wrinkles