

Account Information

DATE _____

NEW ACCOUNT UPDATE

CUSTOMER INFORMATION

Clinic or Business Name _____

Street Address _____ City _____ State _____ Zip _____

Phone _____ Fax _____ Website _____

Primary Contact _____ Title _____

Direct Phone _____ Email _____

Medical Director/Physician Name _____ #Doctors in Office _____

Other Physician Names & Specialties _____

PLEASE CHECK TYPE OF BUSINESS

- Plastic Surgery Dermatology
 Facial Plastic Surgery Ophthalmology
 Dental Other Medical _____

PLEASE LIST NAMES AND POSITIONS OF YOUR SKIN CARE STAFF

SERVICES OFFERED IN OFFICE

- Chemical Peels _____ Microdermabrasion _____
 Lasers _____ Injectables _____
 IPL/BBL _____ Other _____

PLEASE LIST OTHER SKIN CARE PRODUCTS DISPENSED IN OFFICE

ADDITIONAL LOCATION (Please provide information on additional locations supplying skin care products)

Street Address _____ City _____ State _____ Zip _____

Phone _____ Fax _____ Website _____

Contact _____ Title _____

Direct Phone _____ Email _____

FOR OFFICE USE ONLY

Account Executive _____

Clinic Relations Associate _____