

PATIENT REGISTRATION FORM

First Name: _____ Middle Initial: ____ Last Name: _____

Address: _____ Apt: ____ City _____ State _____ ZIP: _____

Home Phone: () _____ Email Address: _____

Occupation: _____ Employer: _____ Work #: () _____

Date of Birth: _____ Age: _____ Sex: M() F() Social Security #: _____

Driver's License number: _____ Marital Status: S() M() W() D()

Spouse's Name: _____ Spouse's Occupation: _____

Spouse's Work #: () _____

Closest relative other than Spouse: _____ Phone: () _____

How did you first hear about our office? _____

May we thank the person that referred you to us? yes no

Please Check Procedures You Are Interested In:

- Acne Treatments Anti-Aging Treatments Body Contouring Botox® Cellulite Therapy Chemical Peels Cosmetic Surgery
 Dermal Fillers Excessive Sweating Hormone Replacement Laser Hair Removal Lipo-Dissolve Medical Grade Skin Care
 Microdermabrasion Skin Tightening Spider/Varicose Vein Therapy Other _____

What did you see, hear or feel that brings you to seek information at this time? _____

Have you discussed this with your: Spouse Family Friends

If so, their opinion was: Supportive Uncommitted Against It

Have you had a prior consultation with another doctor? Yes No

Have you had any other cosmetic surgery procedures? Yes No

If yes, please list: _____

What (if any) are your concerns about this procedure? _____

When are you planning on having your procedure done? _____

How will you pay for the services rendered? Cash M/C Visa Financing

This information is accurate and true to the best of my knowledge.

Signature _____ Date _____

The information will be kept confidential. If you need help, our staff can assist you.

Please print your NAME: _____ Your AGE: _____

Height: _____ Current Weight: _____

How is your general HEALTH? _____ Are you under a DOCTOR'S care? _____

List all MEDICATIONS you are currently taking:

PRESCRIPTION _____

NON PRESCRIPTION (aspirin, cold tablets, etc.) _____

VITAMINS &/or HERBS _____

List all drugs to which you are ALLERGIC: _____

OTHER allergies (bee sting, food, etc.) _____

Do you SMOKE? _____ If yes how much (per day, week)? _____

Do you DRINK alcoholic beverages? _____ If yes, how much? _____

Have you used or do you now use recreational DRUGS? _____ If yes, list: _____

Date of Last Menstruation: _____

OPERATIONS/HOSPITALIZATIONS
you have had:

Major ILLNESSES and INJURIES you have had:

Are you HIV positive? _____ List any significant hereditary or infectious diseases in your family (i.e.

Diabetes, heart disease, TB, etc.): _____

Has any BLOOD RELATIVE of yours ever had any problem with ANESTHESIA? _____

HAVE YOU EVER HAD OR DO YOU NOW HAVE ANY OF THE FOLLOWING CONDITIONS?

Please circle yes or no

Glaucoma or blurry vision	(yes)	(no)	Recurrent severe dizziness	(yes)	(no)
Severe headaches	(yes)	(no)	Chronic sinus problems	(yes)	(no)
Asthma	(yes)	(no)	Shortness of breath	(yes)	(no)
Chest Pain	(yes)	(no)	Heart problems	(yes)	(no)
High Blood Pressure	(yes)	(no)	Rheumatic fever	(yes)	(no)
Recurrent abdominal problems	(yes)	(no)	Blood in bowel movements	(yes)	(no)
Kidney or bladder problems	(yes)	(no)	Blood in urine	(yes)	(no)
Bleeding disorder, easy bruising	(yes)	(no)	Seizures	(yes)	(no)
Pregnancies	(yes)	(no)	Menstrual disorder	(yes)	(no)
Abnormal lump or node	(yes)	(no)	Problems with bones or joints	(yes)	(no)
Hepatitis	(yes)	(no)	Tuberculosis	(yes)	(no)
Venereal disease	(yes)	(no)	Cancer	(yes)	(no)
Diabetes	(yes)	(no)	Chronic skin condition	(yes)	(no)
Emotional problems	(yes)	(no)	Psychiatric treatment	(yes)	(no)
Problems with anesthesia	(yes)	(no)	Complications after surgery	(yes)	(no)
A bad surgical result	(yes)	(no)	Unsatisfactory medical care	(yes)	(no)
Blood Clots	(yes)	(no)			

Other: _____

IMPORTANT: Have you ever taken any type of diet medication? _____

Name of medication _____ When did you last take this medication? _____

THE PRECEEDING INFORMATION IS ACCURATE AND TRUE TO THE BEST OF MY KNOWLEDGE.

Patient signature

Date completed

Reviewed by

Date

Reviewed by

Date

Reviewed by

Date

Reviewed by

Date

Statement of Understanding

I agree that the determination of professional services to be rendered by my Doctor and the fees to compensate him for these services are matters concerning my Doctor and me. I understand that I have the primary duty and obligation to pay my Doctor for his services. Notwithstanding any contract I may have with any third party (be it an insurance company, employer, union, government or the like.)

Neither my Doctor nor I will permit any third party to determine what medical services I need or what fees the Doctor should receive in return for these services. Any agreement that either of us may have with any third party shall not affect our Doctor-Patient relationship and the decisions relating to medical care and fees. Neither my doctor nor I as the Patient are in any way bound by any contract the other may have with any third party.

Patient: _____

Date: _____

Witness: _____

Date: _____

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

Print Name: _____

Signature: _____

Date: _____