Patient Information

Name		Birth Date	❑ Single ❑ Married ❑ Widowed ❑ Divorced
Home Phone	Home Address		Zip
Cell Phone	e-mail Address		
Business Phone	Business Address		
Occupation		Employer	
Social Security Number		Who is responsible for this account?	
If a college student – Name of college or university currently attending			Method of Payment : Cash Check Credit Card
Spouse's Name		Daytime Phone Number	
Parent's Names (If patient is a minor)			
Person to contact in an emergency		Relationship	Phone Number(s)
Other family members who come to this office			
Whom may we thank for referring you here?			

Medical Information

Name and Phone Number of Personal Physician:
Name, Type, and Phone Number of Other Doctors currently seeing:
Are you seeing a Doctor for a medical condition? If yes, please explain.
List any illness or surgery within the last 5 years:

***Please Note*: Medications, Dietary Supplements , Vitamins, and Herbal Regimens can sometimes have effects on Cosmetic Procedures.** **Please List any you are currently taking. (If you have a list with you, we will gladly make a copy.)**

Have You Ever Had an Allergic or Undesirable Reaction To:

YES	NO		YES	NO	
❑	❑	Local Anesthetics (Novocaine, etc…?)	❑	❑	Penicillin or Other Drugs? Please list _____
❑	❑	Oral Surgery or Tooth Extractions?	❑	❑	Acrylic, Latex, Jewelry, or Metals?
❑	❑	Juvederm	❑	❑	Botox

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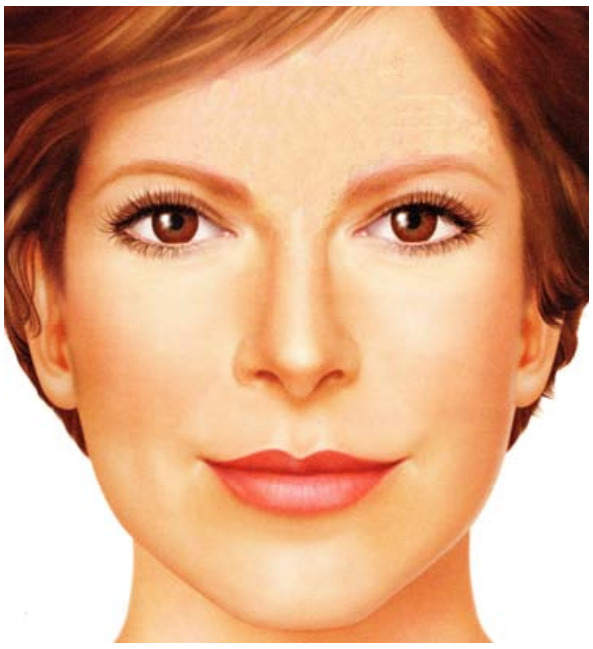
Do You Have OR Have You Ever Had:

YES	NO		YES	NO		YES	NO	
❑	❑	Rheumatic Fever	❑	❑	Hay Fever or Allergies	❑	❑	Artificial Joint Replacement
❑	❑	Heart Trouble or Murmur	❑	❑	Asthma or Other Breathing Problems	❑	❑	Fever over 99 deg., longer than 30 days
❑	❑	Mitral Valve Prolapse	❑	❑	Sinusitis	❑	❑	Lumps in Neck, Groin, Armpits
❑	❑	Heart Surgery	❑	❑	Tuberculosis or Other Lung Disease	❑	❑	White Spots/Sores in Mouth
❑	❑	High or Low Blood Pressure	❑	❑	Diabetes	❑	❑	Frequent Headaches
❑	❑	Chest Pains	❑	❑	Kidney or Urinary Problems	❑	❑	Drug Addictions
❑	❑	Swelling of Feet or Ankles	❑	❑	Radiation Treatment or Chemotherapy	❑	❑	Tested Positive for HIV
❑	❑	Stomach or Digestive Trouble	❑	❑	Cancer or Tumor	❑	❑	Are You Pregnant or Breast Feeding
❑	❑	Anemia or Bleeding Disorder	❑	❑	Convulsions, Seizures or Fainting	❑	❑	ALS or other Muscle or Nerve Disorder
❑	❑	Jaundice or Liver Problems	❑	❑	Arthritis	❑	❑	Myasthenia Gravis
❑	❑	Hepatitis: A B Delta Unknown	❑	❑	Hormonal Disturbances or Treatment	❑	❑	Botox or Juvederm in last 4 months
❑	❑	Sexually Transmitted Diseases	❑	❑	Skin Infections	❑	❑	Other? Please Specify _____

I Am Here to Have the Following Areas Evaluated:

- ❑ Fine Lines and Wrinkles
- ❑ Lines around Nose and Mouth
- ❑ Frown Lines
- ❑ Fuller Lips
- ❑ Sagging Skin
- ❑ Drooping Eyebrows
- ❑ None of These Concern Me.
- ❑ Other_____



Please draw in the areas you wish to consult about

This is to certify that I, the undersigned, consent to the performing of the cosmetic procedures agreed to, including the use of local anesthesia as indicated. Also, that I am responsible for the full fees charged to me for those services.

X

Patient's (or Parent's) Signature Date