REJUVENATION
medical aesthetics

PATIENT REGISTRATION - CONFIDENTIAL

PLEASE COMPLETELY PRINT THE FOLLOWING AND SIGN BELOW

PATIENT INFORMATION

FIRST NAME	MI	LAST NAME	SSN#	BIRTHDATE	SEX

ADDRESS	APT, SUITE	CITY, STATE, ZIP

HOME PHONE	WORK PHONE	CELL PHONE	MARITAL STATUS	LANGUAGE

EMAIL ADDRESS (*FOR APPOINTMENT REMINDERS & COMMUNICATIONS*)	PHARMACY NAME AND PHONE NUMBER

PRIMARY CARE PHYSICIAN	REFERRING PHYSICIAN

HOW WOULD YOU LIKE YOUR APPOINTMENT CONFIRMED?

□ Automated Phone Call □ Email □ Text

HOW DID YOU HEAR ABOUT US?

EMERGENCY CONTACT NAME	EMERGENCY CONTACT PHONE	GUARDIAN LAST NAME	GUARDIAN FIRST NAME

EMERGENCY CONTACT RELATIONSHIP	PATIENT EMPLOYER NAME

REQUEST FOR CONFIDENTIAL COMMUNICATION OF PROTECTED HEALTH INFORMATION "HIPPA"

THE FOLLOWING PERSONS MAY RECEIVE AND DISCUSS INFORMATION REGAURDING MY HEALTH CARE:

NAME	PHONE NUMBER
NAME	PHONE NUMBER

MEDICATION LIST

WHAT MEDICATIONS ARE YOU CURRENTLY ON?

WHAT MEDICATIONS ARE YOU ALLERGIC TO?

MEDICAL HEALTH HISTORY

DO YOU CURRENTLY HAVE ANY OF THE FOLLOWING MEDICAL PROBLEMS OR HAVE HAD ANY IN THE PAST? Check all that apply to you or a family member.

□ Neurological Issues □ Stroke □ Diabetes □ Heart Attack □ Cancer

IF YOUR ANSWER IS YES, TO ANY OF THE ISSUES ABOVE, PLEASE EXPLAIN:

ARE YOU CURRENTLY PREGNANT OR NURSING?

□ Yes □ No

ARE YOU INTERESTED IN? (Check all that apply):

□ Fat Reduction or Coolsculpting
□ Hair Restoration
□ Skin Rejuvenation for the Eyes or Face
□ Botox® for facial lines
□ Dermal Fillers to Add Volume to the Face
□ Permanent Hair Removal
□ LASIK – Laser Vision Correction
□ Cosmetic Eyelid Surgery
□ Latisse® for Growing Longer Eyelashes
□ Removing Facial Vessels/Skin Tags
□ Removing/Reducing Brown, Liver or Age Spots
□ Kybella: Double Chin Fat Reduction

_____ _____ / / _____

Signature of Patient/Patient's representative Date