THE BEAUTY CLINIC

Welcome to The Beauty Clinic. We look forward to providing you with excellent care in aesthetics. Please fill out the following information so we may best serve you.

Dr. Lital Kathein • Nurse Practioner Nicole Ross

PATIENT INFORMATION

TODAY'S DATE: _____

FIRST NAME: _____ LAST NAME: _____

HOME ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____ COUNTRY: _____

AGE: _____ ___ DATE OF BIRTH (mm/dd/yy): _____ MARITAL STATUS: ☐ Single ☐ Married

SEX: ☐ M ☐ F EMAIL ADDRESS (For our office use only): _____

HOME PH #: (_____)_____ CELL PH #: (_____)_____ WORK PH #: (_____)_____

EMPLOYER: _____ OCCUPATION: _____

HOW DID YOU HEAR ABOUT US? REFERRAL: Who referred you to us? _____

ONLINE: ☐ Google ☐ Facebook ☐ Instagram ☐ other _____

EVENT: ☐ Seminar ☐ Bridal show ☐ Spa/Salon event at _____

MAILING: ☐ Magazine ☐ Postcard

EMERGENCY CONTACT

NAME OF PERSON WE SHOULD CONTACT IN CASE OF EMERGENCY: _____

RELATIONSHIP: _____ HOME PH #: (_____)_____ CELL PH #: (_____)_____

PLEASE TELL US ABOUT YOURSELF

Reason for today's visit: _____

Have you had Botox® treatment in the past? ☐ Yes ☐ No If yes, how long ago? _____

Have you had facial fillers (such as Juvederm®, Restylane, Perlane, Voluma™) in the past? ☐ Yes ☐ No

If yes, how long ago? _____

Are you interested in learning more about: (check all that apply)

☐ Botox ☐ Botox for headaches ☐ Botox for sweating ☐ Filler
☐ Laser for brown spots ☐ Laser for blood vessels ☐ PRP for thin hair ☐ PRP for skin rejuvenation
☐ Chemical peels ☐ Medical grade skincare ☐ Skin tightening ☐ Laser resurfacing

Do you clench your teeth? ☐ Yes ☐ No Do you have TMJ pain? ☐ Yes ☐ No Do you get frequent headaches? ☐ Yes ☐ No

I, the undersigned (patient or legally responsible party), authorize treatment to be rendered by the doctor and his/her staff, and I assume all financial responsibility for treatment given, services rendered and all associated costs incurred as a result of my treatment. I acknowledge that all the information contained herein is true and correct and give my permission to verify any of the information provided. I, the undersigned (patient or legally responsible party), have reviewed the HIPAA Privacy Policy Notice available in the office of The Beauty Clinic.

SIGNATURE OF PATIENT (or Parent/Guardian): _____ DATE: _____

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YOUR MEDICAL INFORMATION

Name of primary doctor: _____ Phone number: _____

Are you under a physician's care for any medical condition? ☐Y ☐N If yes, please explain: _____

Have you ever been hospitalized or had a major operation? ☐Y ☐N If yes, please explain: _____

PLEASE LIST ALL THE **MEDICATIONS**, PILLS, OR DRUGS THAT YOU ARE TAKING: _____

_____

ARE YOU **ALLERGIC** TO ANY OF THE FOLLOWING?

☐Aspirin ☐Penicillin ☐Codeine ☐Acrylic ☐Metal ☐Latex ☐Sulfa drugs ☐Local Anesthetics

☐Other allergies_____

Do you drink alcohol? ☐Y ☐N If yes, how much/how often? _____

Do you smoke or use tobacco? ☐Y ☐N If yes, how much/how often? _____

WOMEN ONLY: Are you pregnant or trying to get pregnant? ☐Y ☐N If pregnant, how many weeks? _____

Are you taking oral contraceptives? ☐Y ☐N Are you nursing? ☐Y ☐N

In order to safely treat you and make proper diagnoses, it is important that we know your medical conditions.

Do you have, or have you had, any of the following?

AIDS/HIV Positive ☐Y ☐N	Cortisone Medicine ☐Y ☐N	Hepatitis A ☐Y ☐N	Renal Dialysis ☐Y ☐N
Alzheimer's Disease ☐Y ☐N	Diabetes ☐Y ☐N	Hepatitis B or C ☐Y ☐N	Rheumatic Fever ☐Y ☐N
Anaphylaxis ☐Y ☐N	Drug Addiction ☐Y ☐N	Herpes ☐Y ☐N	Rheumatism ☐Y ☐N
Anemia ☐Y ☐N	Easily Winded ☐Y ☐N	High Blood Press. ☐Y ☐N	Scarlet Fever ☐Y ☐N
Angina ☐Y ☐N	Emphysema ☐Y ☐N	High Cholesterol ☐Y ☐N	Shingles ☐Y ☐N
Arthritis/Gout ☐Y ☐N	Epilepsy or Seizures ☐Y ☐N	Hives or Rash ☐Y ☐N	Sickle Cell Disease ☐Y ☐N
Artificial Heart Valve ☐Y ☐N	Excessive Bleeding ☐Y ☐N	Hypoglycemia ☐Y ☐N	Sinus Trouble ☐Y ☐N
Artificial Joint ☐Y ☐N	Excessive Thirst ☐Y ☐N	Irregular Heartbeat ☐Y ☐N	Spina Bifida ☐Y ☐N
Asthma ☐Y ☐N	Fainting/Dizziness ☐Y ☐N	Kidney Problems ☐Y ☐N	Stomach/GI Disease ☐Y ☐N
Blood Disease ☐Y ☐N	Frequent Cough ☐Y ☐N	Leukemia ☐Y ☐N	Stroke ☐Y ☐N
Blood Transfusion ☐Y ☐N	Frequent Diarrhea ☐Y ☐N	Liver Disease ☐Y ☐N	Swelling of Limbs ☐Y ☐N
Breathing Problem ☐Y ☐N	Frequent Headaches ☐Y ☐N	Low Blood Pressure ☐Y ☐N	Thyroid Disease ☐Y ☐N
Bruise Easily ☐Y ☐N	Genital Herpes ☐Y ☐N	Lung Disease ☐Y ☐N	Tonsillitis ☐Y ☐N
Cancer ☐Y ☐N	Glaucoma ☐Y ☐N	Mitral Valve Prolapse ☐Y ☐N	Tuberculosis ☐Y ☐N
Chemotherapy ☐Y ☐N	Hay Fever ☐Y ☐N	Osteoporosis ☐Y ☐N	Tumors of Growth ☐Y ☐N
Chest Pain ☐Y ☐N	Heart Attack/Failure ☐Y ☐N	Pain in Jaw Joints ☐Y ☐N	Ulcers ☐Y ☐N
Cold Sores/Fever Blister ☐Y ☐N	Heart Murmur ☐Y ☐N	Parathyroid Disease ☐Y ☐N	Venereal Disease ☐Y ☐N
Congenital Heart Disorder ☐Y ☐N	Heart Pace Maker ☐Y ☐N	Psychiatric Care ☐Y ☐N	Weak Immune System ☐Y ☐N
Convulsions ☐Y ☐N	Heart Trouble/Disease ☐Y ☐N	Radiation Treatments ☐Y ☐N	Yellow Jaundice ☐Y ☐N

Have you ever had any serious illness not listed above? ☐Y ☐N If yes, please explain: _____

Do you need to be premedicated before dental treatment? ☐Y ☐N If yes, please explain: _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing inaccurate information can be dangerous to the health of the patient. It is my responsibility to inform this office of any changes in my medical status.

SIGNATURE OF PATIENT (or Parent/Guardian): _____ DATE: _____