Ageless Rejuvenation & Aesthetics, LLC

PATIENT REGISTRATION FORM

Name: ____

Birth Date: ___________________________ Sex: MALE | FEMALE

Marital Status: SINGLE / MARRIED / DIVORCED / WIDOW / SEPARATED

Primary Phone: (_____)_____________________________

Address: ____

Email Address: ____

Occupation: ___________________________ Employer (optional)________________________

Primary Doctor Name ____

Primary Doctor Phone: (_______)___________________________

Emergency Contact Name: ____

Relationship: _______________________________ Phone (_______)____________________

AREAS OF INTERSEST REGRADING YOUR SKIN:

☐ Facial Wrinkles	☐ Acne Scars	☐ Lines Between Eyes
☐ Skin Discoloration	☐ Facial Redness	☐ Lip Lines
☐ Facial Volume Loss	☐ Aging Hands	☐ Skin Care
☐ Skin Tightening	☐ Age Spots / Brown Spots	

Other: ____

CURRENT MEDICAL CONDITIONS:
Have You Ever Seen A Physician For Any Of The Following Condition? (Mark ALL That Apply)

☐ Blood Disease	☐ Keloid Scars	☐ Skin Lesions
☐ Cold Sores	☐ Seizures	☐ Rosacea
☐ Cold Sores Diabetes	☐ High Blood Pressure	☐ Polycystic Ovarian Syndrome
☐ Melasma	☐ HIV/AIDS	☐ Sexually Transmitted Disease
☐ Hepatitis	☐ Glaucoma	

Cancer (specify): ____

Other Conditions NOT Listed: ____

Ageless REJUVENATION & AESTHETICS

Are You Currently Taking Or Have Taken Any Of The Following Medications?

☐ Accutane	☐ Estrogen	☐ Birth Control
☐ Chemotherapy	☐ Testosterone	☐ Hydroquinone
☐ NSAIDS	☐ Anabolic Steroids	☐ Thyroid Medications
☐ Blood Thinners	☐ Aldactone	☐ Antidepressants
☐ Minoxidil	☐ DHEA	☐ Hormones
☐ Retin A	☐ Antibiotics	

Please list any other medications you are currently taking: ______________________________________

____

Please list any known allergies to medications, foods, etc.:______________________________________

____

Are you pregnant, possibly pregnant, or considering pregnancy in the near future?: YES / NO

Are you lactating?: YES / NO

Please mark any previous cosmetic facial treatment you have received:

☐ Botox	☐ Chemical peel	☐ Dermal Fillers
☐ Tattoo	☐ IPL Treatments	☐ Facial Surgery
☐ Tanning/ Spray Tanning (Within The Last 4 Weeks)	☐ Laser Treatment	☐ Permanent Makeup
☐ Microdermabrasion		

FITZPATRICK SKIN CHART:

Please circle the category that best describes your skin type:	**Please circle the category that best describes your skin color and tendency to burn:**
1. Problematic (Acne, Psoriasis, Rosacea, Eczema)	1. Very pale or freckled, always sunburns
2. Oily	2. Pale, usually sunburns
3. T-Zone or Combination	3. Pale to olive, sometimes sunburns
4. Normal	4. Olive to brown, rarely sunburns
5. Dry	5. Dark brown, very rarely sunburns
6. Sensitive (Allergic reactions to some skin care products)	6. Black, never sunburns

Do we have your permission to take "Before and After" photographs for your chart? YES / NO

If you answered YES to the previous question, do you grant us permission to use your photographs for Ageless Rejuvenation & Aesthetics, LLC marketing materials and purposes? YES / NO

(Referral) Please Tell Us Who Told You About Us So We Can Reward Them:

____

With Rejuvenation Credits ____

I have answered all of the preceding questions to the best of my knowledge and will notify Ageless Rejuvenation & Aesthetics, LLC of any changes in medications or any changes in my physical condition. I have been informed of Ageless Rejuvenation & Aesthetics, LLC's privacy policy. If I have given permission to leave detailed messages or email information regarding my care, and/or discuss my medical care with specific family and/or friends, I understand that I am granting a waiver of my privacy rights under HIPAA. If I decide to change these instructions, I will notify Ageless Rejuvenation & Aesthetics, LLC in writing as soon as possible, I understand that if I provide my email address, that email is not privacy protected.

Patient Signature: ________________________________ Date: ____________________

Patient Name : __________________________________ Date of Birth:______________