



PERSONAL INFORMATION

Date _____

Name _____
 First MI Last

Address _____

City _____ State _____ Zip _____

Email _____

Home Phone (_____) _____

Work Phone (_____) _____

Cell Phone (_____) _____

Please indicate the best contact number/email to confidentially remind you of your appointment:
 Email Home Phone Work Phone Cell Phone

Date of Birth _____ Age _____

Marital Status: S M D Sex: M F

Occupation _____

Name of Employer _____

Name of Emergency Contact _____

Relationship to you _____

Emergency Phone (_____) _____

REFERRAL INFORMATION

If you were referred by a friend, please list their name so we may thank them.

If you were referred by a doctor, please list their name:

If not referred by one of the above, how did you hear about us?

If internet, what search engine and topic did you use?

CONCERNS

What concerns would you to discuss, have evaluated and /or treat?

MEDICAL HISTORY

List any allergies you have: _____

List illnesses, surgeries and hospitalizations within the past 3 years

Are you currently under the care of a healthcare professional? Yes No

If so, please list name and specialty:

Please list any medications, vitamins, herbs or dietary supplements taken and dosage:

List physical activities you participate in regularly

MEDICAL HISTORY (continued)

Have you ever been treated for, diagnosed as having, or are you currently suffering from any of the following (please give details below):

- Headaches/migraines
- Diabetes
- Chronic illness/pain
- High/low blood pressure
- Fatigue
- Phlebitis/varicose veins
- Sleep Difficulties
- Drug/alcohol/caffeine abuse
- Hay fever/sinus problems
- Skin inflammation or infection
- Hepatitis or liver disease
- Thyroid function disorders
- Intestinal/digestive disorder
- Kidney failure
- Mental/emotional disorders
- Allergies
- Scoliosis
- Sprains/strains
- Neck, shoulder, arm pain
- Neck/spinal injuries
- Numbness/tingling
- Osteoporosis
- Collagen, fat, cortisone injections
- Acute allergic reactions
- Acute infections
- Chronic inflammation
- Heart Disease
- Cancer/Malignant Tumors
- HIV Positive or AIDS
- Kidney/bladder ailments
- Thrombosis/embolism
- Blood clots
- Vision problems
- Ovarian/menstrual problems
- Infectious disease
- Depression
- Hypertension
- Abdominal or inguinal hernias
- Respiratory disease
- Bruise easily
- Hormonal treatment
- Muscle or joint pain
- Arthritis/bursitis/gout
- Low back, hip, leg pain
- Head injuries
- Broken/fractured bones
- Tendonitis
- Sciatica
- Recent/current Ongoing
- Recent/current Ongoing
- Recent/current Ongoing

Women only:

Using contraceptive pills? Yes No

If type or dosage has recently changed, please list type and/or new dosage below:

Irregular menstruation? _____

Endometriosis? _____

Are you pregnant? _____

If so, how many months? _____

Details:

CANCELLATION POLICY

Ageless requires a 24 hour notice to cancel or reschedule an appointment. Please be advised that any client canceling or rescheduling within 24 hours of their appointment will be charged for the scheduled appointment or procedure.

Signature _____

PAYMENT POLICY

Ageless does not participate with any insurance company and can not guarantee that any appointment or procedure will be covered under insurance. However, we will give you procedure and diagnosis codes so that you may submit the claim to your health insurance carrier for reimbursement. **Payment for services are the patient's responsibility and are due at the time of service. We accept cash, check, Visa or MasterCard and American Express.**

Signature _____

CONSENT

I give my consent for examination and treatment as necessary.

Signature _____

CONSENT FOR MINORS/CHILDREN

If the client is a minor, Ageless, Center for Rejuvenation, has my permission to treat my child.

Parent or Guardian (please print) _____

Signature _____

We have a legal obligation to keep health information that identifies you private. We are obligated by law to give you notice of our privacy practices and you will be given a copy to keep. It describes how we protect your health information and what rights you have regarding it. Please review and sign the last page of the notice confirming you have received your copy.

Cosmetic Questionnaire

To help us better serve you; please check the cosmetic issues, treatments or procedures of interest to you. (Please check all that apply)

- BOTOX® Cosmetic
- Thermage
- Wrinkle removal
- Wrinkle fillers
- Immediate results
- Gradual results
- Temporary changes
- Long lasting or “permanent” results
- Lip enhancement or Augmentation
- Lip line improvement
- Restylane
- Collagen
- Juvederm
- Evolence
- Radiesse
- Sculptra
- Liposuction
- Face Lift – Surgical
- Face Lift – Non-surgical
- Eyelid Lift
- Cellulite Treatment
- Mesotherapy
- AHA and Glycolic Peels
- Microdermabrasion
- Neck Treatments
- Chemical Peels
- Laser Resurfacing
- Laser Treatments
- Photorejuvenation / IPL
- Nutritional Supplements
- Skin Care Advice
- Skin Care Products
- Sun Spots
- Under Eye Circles
- Lipodissolve
- Age Spots
- Removing Leg Veins
- Rosacea Treatments
- Facials and Eye Treatments
- Laser Hair Removal
- Spider Vein Treatments
- Removing Facial Veins
- Makeover / Make-up
- Micro Current Treatment
- Weight Loss
- Latisse Eyelash Growth serum
- Uneven skin color or pigment
- Skin textural problems
- Other _____
- _____
- _____

