**PLEASE PROVIDE THE RECEPTIONIST WITH YOUR PHOTO ID**

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| **Patient’s Name** | | | | | | |  | | | | | | | | | | | | | | |  | | | | | | | | | | |  | | | | | | | | | | | | |
|  | | | | | | | First, Middle, Last | | | | | | | | | | | | | | |  | | | | | | | | | | | Date | | | | | | | | | | | | |
| Address | | |  | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | |  | | | | | |  | | |
|  | | | Street & Apt # | | | | | | | | | | | | | | | | | | | | | | City | | | | | | | | | | | State | | | | | | Zip | | |
| Home Phone | | | | |  | | | | | | | | | | Cell Phone | | | | | | |  | | | | | | | | Other Phone | | | | | | | | |  | | | | | |
| Any restrictions for contacting you? | | | | | | | | | | | | |  No  Yes | | | | | | | | E-mail | | | | |  | | | | | | | | | | | | | | | | | |
| Contact Restrictions: | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Age | |  | | | Birthdate | | | | | | / / | | | | | | SS# | | | |  | | | | | | | | Gender: | | | | | Female Male Transgender | | | | | | | | | | |
| Relationship Status : Single Engaged Married Divorced Widow Partner Other | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Patient’s Employer** | | | | | | | | | |  | | | | | | | | | | | | | | | | | Occupation | |  | | | | | | | | | | | | | | | | |
| Work Phone | | | |  | | | | | | | | | | | Ext: | | |  | | | | | | Is it okay to call you at work? | | | | | | | | | | |  Yes  No | | | | | | | | | |
| Address | | |  | | | | | | | | |  | | | | |  | | | | | | | | |  | | | | | | | | | | | |  | | | | |  | |
|  | | | Street & Suite # | | | | | | | | | | | | | | | | | | | | | | | City | | | | | | | | | | | | State | | | | | Zip | |
| **How did you hear about Dr. Nicole?** (mark all that apply) | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | |  | | | | |
|  TV News  TV Ad  Phone Book  Magazine  Billboard  Seminar  Salon  Web | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  Friend/Relative: | | | | | | |  | | | | | | | | | | | |  Doctor: | | | | | | |  | | | | | | | | | | |  Other: | | | |  | | | |
| If you were referred by a specific person, may we thank them?  Yes  No | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Emergency Contact** | | | | | | | | |  | | | | | | | | | | | | | | | | | | Relationship to Patient | | | | | | |  | | | | | | | | | | | |
| Home Phone | | | | |  | | | | | | | | Work Phone | | | | | | |  | | | | | | | Cell Phone | | | | | | |  | | | | | | | | | | |
| **Areas of Interest:** (mark all that apply) | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Facial Procedures** | | | | | | | | | | | | | | **Breast/Body Procedures** | | | | | | | | | | | | | | | | | **Other Procedures** | | | | | | | | | | | | | |
|  PRP treatment | | | | | | | | | | | | | |  Breast augmentation | | | | | | | | | | | | | | | | |  Hair loss treatment | | | | | | | | | | | | | |
|  Eyelid rejuvenation | | | | | | | | | | | | | |  Breast Implant removal | | | | | | | | | | | | | | | | |  Skin Care | | | | | | | | | | | | | |
|  Botox™ / Dysport | | | | | | | | | | | | | |  Gynecomastia Treatment | | | | | | | | | | | | | | | | | |  | | --- | |  Vaginal atrophy/tightening | | | | | | | | | | | | | | |
|  Brow Lift | | | | | | | | | | | | | |  Breast Reduction | | | | | | | | | | | | | | | | |  Cellulite reduction | | | | | | | | | | | | | |
|  Face rejuvenation | | | | | | | | | | | | | |  Mastopexy (Breast Lift) | | | | | | | | | | | | | | | | |  Lesions / Moles / Warts | | | | | | | | | | | | | |
|  Morpheus/Secret RF | | | | | | | | | | | | | | |  | | --- | |  Abdominoplasty (Tummy Tuck) | | | | | | | | | | | | | | | | | |  Hand Rejuvenation | | | | | | | | | | | | | |
|  Laser Skin Resurfacing | | | | | | | | | | | | | |  Arm lift | | | | | | | | | | | | | | | | |  Y-lift | | | | | | | | | | | | | |
|  Lip Enhancement | | | | | | | | | | | | | | |  | | --- | |  Skin tightening | | | | | | | | | | | | | | | | | |  Eyelash enhancement | | | | | | | | | | | | | |
|  Nonsurgical facelift | | | | | | | | | | | | | |  Liposuction – abdomen, | | | | | | | | | | | | | | | | |  Spider Veins | | | | | | | | | | | | | |
|  Wrinkle Fillers (Injections) | | | | | | | | | | | | | | hips, thighs, arms, other | | | | | | | | | | | | | | | | |  Permanent sweat reduction | | | | | | | | | | | | | |
|  Permanent makeup | | | | | | | | | | | | | | |  | | --- | |  Labiaplasty | | | | | | | | | | | | | | | | | |  Laser hair removal | | | | | | | | | | | | | |

**Patient name:**

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Date of birth: Age: | | | | | Weight lbs Height ft in | | | |
| What surgery or procedure(s) are you considering? | | | | | **OFFICE USE ONLY**  **BMI =** | | | |
| Migraines or Headaches | Yes | | No | | Glaucoma | Yes | No | |
| History of skin cancer  (list type & location if known): | Yes | | No | | Other eye problems : please specify | Yes | No | |
| Skin Disorders – eczema, psoriasis, vitiligo or other skin condition | Yes | | No | | Glasses or contacts | Yes | No | |
| Heart Procedure | Yes | | No | | Use of eye drops (any type) | Yes | No | |
| Palpitation or Irregular Pulse | Yes | | No | | LASIK eye surgery | Yes | No | |
| Heart Attack | Yes | | No | | Yellow Jaundice | Yes | No | |
| Stroke | Yes | | No | | Gallstones/Gallbladder Trouble | Yes | No | |
| Hypertension (high blood pressure) | Yes | | No | | Cirrhosis of the Liver | Yes | No | |
| Blood Pressure Abnormalities | Yes | | No | | Alcoholism or Drug Dependency | Yes | No | |
| Abnormal EKG | Yes | | No | | Esophageal Varices | Yes | No | |
| Rheumatic Fever | Yes | | No | | Heartburn or Indigestion | Yes | No | |
| Heart Failure | Yes | | No | | Ulcers | Yes | No | |
| High cholesterol | Yes | | No | | Gastritis | Yes | No | |
| Shortness of Breath | Yes | | No | | Colitis | Yes | No | |
| Chest Pain | Yes | | No | | Constipation | Yes | No | |
| Asthma | Yes | | No | | Vomiting Blood | Yes | No | |
| Bronchitis | Yes | | No | | Tarry or Bloody Bowel Movements | Yes | No | |
| Pneumonia | Yes | | No | | Goiter or Thyroid Disorders | Yes | No | |
| Tuberculosis | Yes | | No | | Diabetes | Yes | No | |
| Smokers Cough | Yes | | No | | Autoimmune disease (please specify) | Yes | No | |
| Emphysema | Yes | | No | | Arthritis | Yes | No | |
| Coughing/ Spitting of Blood | Yes | | No | | Fracture of Neck or Spine | Yes | No | |
| Hay Fever or major allergies | Yes | | No | | Bleeding Tendency or Disorder | Yes | No | |
| Back Pain | Yes | | No | | Abnormal Bleeding After Tooth Extraction | Yes | No | |
| Palsy or Paralysis | | Yes | | No | Breast Cysts, Tumors, Abscesses | Yes | | No |
| Kidney Disorder | | Yes | | No | Nipple Discharge (apart from lactation) | Yes | | No |
| Mammogram or breast ultrasound | | Yes | | No | Nervous Breakdown or Anxiety Disorder | Yes | | No |
| Insomnia | | Yes | | No | Hot flushes or other peri-menopausal symptoms | Yes | | No |
| Poor sleep – difficulty falling or  staying asleep | | Yes | | No | Missed or irregular menstrual cycle | Yes | | No |
| Recreational illegal drug use | | Yes | | No | Radiation treatment in the past  (if yes, list area treated): | Yes | | No |
| Seizures, Convulsions, Fainting | | Yes | | No | Piercing other than the ears | Yes | | No |
| Black outs | | Yes | | No | Dentures, bridges, crowns,  cosmetic bonding to teeth | Yes | | No |
| Blood Transfusion | | Yes | | No | Loose teeth or periodontal disease | Yes | | No |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Positive blood test for HIV, AIDS, Hepatitis | Yes | No | Chemical peels or microdermabrasion | Yes | No |
| Family history of cancer, heart disease  or stroke | Yes | No | IPL/fotofacial | Yes | No |
| Family members with anesthesia problems | Yes | No | Laser hair removal – if yes, please list areas treated: | Yes | No |
| Family members with bleeding or clotting problems | Yes | No | Current or recent use of diet pills | Yes | No |
| Psychiatric Hospitalization or Care | Yes | No | Weight increase or decrease >5 lbs in last 6 months (if yes, circle which) | Yes | No |

1) **Please list all present medications**, including birth control pills, hormones, vitamins, herbal medication, diuretics, and weight loss drugs. **Include over-the-counter medications**.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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2) **Allergies and Sensitivities:**

Local Anesthetics…………………………. Y / N General Anesthetics……………………….. Y / N

Antibiotics (Penicillin/other)……………… Y / N Barbiturates, Sedatives………………….. Y / N

Morphine or Codeine………………………Y / N Adhesive Tapes...………………………… Y / N

Latex…………………………………………Y / N

3) Do you react abnormally to any medication? Yes No Which?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

4) Have you, or any member of your family, ever had any difficulties with any medications, drugs, or gases used for

anesthesia? € Yes € No

If yes, what was the medication & reaction?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

5) Have you ever been on cortisone or steroid treatment? € Yes € No When? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

6) Do you consume alcoholic beverages, including beer, wine, or other alcohol? € Yes € No

If yes, how much? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

7) Do you smoke or use any nicotine products? € Yes € No If yes, what?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Frequency?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

8) Are you pregnant? € Yes € No When was your last normal menstrual period?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What form, if any, of birth control are you using?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever had the following? Please comment if yes.

* Current or history of skin cancer, especially malignant melanoma or recurrent non-melanoma skin cancer, or pre-cancerous lesions. € Yes € No
* Any active infection (including dental, sinus, urinary tract or STD). € Yes € No
* History of fever blisters/cold sores and/or genital herpes. € Yes € No
* Any history of gingivitis or recurrent UTI’s € Yes € No
* Diseases which may be stimulated by light at 790-830 nm, such as history of recurrent Herpes Simplex, Systemic Lupus Erythematous, or Porphyria.. € Yes € No
* Use of photosensitive medication and/or herbs that may cause sensitivity to 790-830 nm light exposure, such as Isotretinoin (Accutane), tetracycline, or St. John's Wort. € Yes € No
* Immunosuppressive diseases, including AIDS and HIV infection, or use of immunosuppressive medications(such as chemotherapy medications) € Yes € No
* History of radiation treatment. If yes, please list area treated: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ € Yes € No
* History of connective tissue diseases, such as rheumatoid arthritis, lupus or scleroderma

€ Yes € No

* History of keloid scarring. € Yes € No
* History of hormonal or endocrine disorders, such as polycystic ovary syndrome or diabetes, unless under control. € Yes € No
* Very dry skin. € Yes € No
* Exposure to sun or artificial tanning during the 3–4 weeks prior to treatment. € Yes € No
* History of a DVT (deep venous thrombosis) and/or PE (pulmonary embolism) € Yes € No
* History of foot swelling or leg edema or wounds/ulcers on your feet or legs € Yes € No
* History of aching, heaviness, itching, burning in your legs € Yes € No
* Tanning bed or sun tanning within the past 6 weeks € Yes € No
* Spray tanning in the last 4 weeks € Yes € No

9) How many pregnancies\_\_\_\_\_\_ Births? \_\_\_\_\_\_\_ Breast fed? € Yes € No If yes, how long?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CHILDREN (list names and ages or birthdates):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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10) When was your last physical exam?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ By whom?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

11) When was your last eye exam?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dental cleaning ?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

12) When was your last chest x-ray?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ EKG?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

13) Who is your personal physician, if any?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list all physicians presently caring for you & include specialty, if known

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14) Have you ever been under psychiatric care or in a substance abuse program? € Yes € No

If yes, when? \_\_\_\_\_\_\_\_\_\_\_\_\_ for what? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

15) Have you had any recent blood work done? € Yes € No When?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

16) Is there anything else you think the doctor should know?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

17) Please list all hospitalizations and surgeries, including procedures done for cosmetic reasons:

SURGICAL OPERATIONS (include where, when, why & complications for each surgery):

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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HOSPITALIZATIONS (include where, when, and why for each admission) :\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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18) Have you had any recent weight gain/loss? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

19) Is there any reason you would not accept a transfusion in an emergency situation? € Yes € No

**Photo Authorization**

The use of photographs is essential to the planning and evaluation of cosmetic surgery. Your surgery or procedure will be photographically documented before, and after the procedure. These photographs are a permanent part of your medical record and will never be shown to anyone else without your consent. For various reasons, Dr. Nicole Castellese is often asked to show before and after photos of patients. Most patients, happy with their results, give permission to use their photos anonymously. At your request, any identifying marks, such as birthmarks or tattoos can be blacked out, and for facial pictures, the eyes may be blacked out. Please note below if such modifications are requested.

I \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ hereby grant Dr. Nicole Castellese/Institute for Beauty, Wellness & Regenerative Medicine and staff permission to photograph me. I further give my irrevocable consent to publish, republish or otherwise transmit the images of myself in any medium for all purposes throughout the world. I understand that the images may be altered or modified in any manner. I understand that every attempt will be made to represent me and Nicole Castellese, MD accurately and with integrity and dignity in all media. I hereby certify that I have read the foregoing and fully understand its meaning and effect.

Please initial areas that may be shown: \_\_\_\_\_Face \_\_\_\_\_ Body \_\_\_\_\_No areas may be shown

Please list specific requests here:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Witness \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |
| --- |
| **I understand that office visit charges are payable on the day service is rendered** |

**I, the undersigned, represent that all of the information on this form is true and complete to the best of my knowledge and that I accept full financial responsibility for professional, medical and surgical services rendered.**

**Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Print Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**