PACIFIC AESTHETIC INSTITUTE

New Patient Registration

Today's Date:	**Social Security Number:**	
Name: *Last*	*First*	*MIddle*
How do you like to be addressed:		**Date of Birth:**
Address: *Street*		
City	*State*	*Zip*
Email Address:		
Preferred Contact Number: ❑ Cell ❑ Home ❑ Work		*Cell Phone:*
Home Phone:		*Work Phone:*

Reason for today's visit: ❑ Botox ❑ Fillers ❑ Facials ❑ Skincare ❑ IPL/Lasers ❑ Surgical Consultation
❑ Other
If surgical consultation, for what procedure?
How did you hear about us? ❑ Friend ❑ Physician ❑ Internet ❑ Radio ❑ Print Media
If you were referred by a person, who may be thank for the referral?
Name: *Last* *First* *MIddle*

Please provide a copy of your driver's license for our records.

Medical History Form

How is your general health? ❑ Good ❑ Average ❑ Poor **Most recent physical examination?** _____

Current Medical Problems:

Anemia	❑ Y	❑ N	Depression	❑ Y	❑ N	Hypothyroidism	❑ Y	❑ N
Arthritis	❑ Y	❑ N	Diabetes	❑ Y	❑ N	Kidney Disease	❑ Y	❑ N
Asthma	❑ Y	❑ N	Glaucoma	❑ Y	❑ N	Mitral Valve Prolapse	❑ Y	❑ N
AIDS/HIV	❑ Y	❑ N	Heart Disease	❑ Y	❑ N	Rheumatic Fever	❑ Y	❑ N
Bleeding Disorder	❑ Y	❑ N	Hepatitis	❑ Y	❑ N	Stomach Ulcer	❑ Y	❑ N
Breast Cancer	❑ Y	❑ N	High Blood Pressure	❑ Y	❑ N	Stroke	❑ Y	❑ N
Cancer	❑ Y	❑ N	Hyper-thyroidsim	❑ Y	❑ N			

Other:_____

_____

_____

_____

Previous Surgeries: (Type/Date/Surgeon/Complications or difficulties)

_____

_____

_____

_____

_____

Previous Plastic Surgeries: (Type/Date/Surgeon/Complications or difficulties)

_____

_____

_____

_____

Family History of Medical Problems:

Anemia	❑ Y	❑ N	Depression	❑ Y	❑ N	Hypothyroidism	❑ Y	❑ N
Arthritis	❑ Y	❑ N	Diabetes	❑ Y	❑ N	Kidney Disease	❑ Y	❑ N
Asthma	❑ Y	❑ N	Glaucoma	❑ Y	❑ N	Mitral Valve Prolapse	❑ Y	❑ N
AIDS/HIV	❑ Y	❑ N	Heart Disease	❑ Y	❑ N	Rheumatic Fever	❑ Y	❑ N
Bleeding Disorder	❑ Y	❑ N	Hepatitis	❑ Y	❑ N	Stomach Ulcer	❑ Y	❑ N
Breast Cancer	❑ Y	❑ N	High Blood Pressure	❑ Y	❑ N	Stroke	❑ Y	❑ N
Cancer	❑ Y	❑ N	Hyperthyroidsim	❑ Y	❑ N			

Other:_____

_____

_____

Do you smoke? ❑ Yes ❑ No How many packs per day? _____ How many years? _____

Do you drink alcoholic beverages? ❑ Yes ❑ No **If yes:** ❑ Infrequently ❑ Socially ❑ Frequently

Do you use recreational drugs? ❑ Yes ❑ No

Do you have a bleeding disorder or bleed easily? ❑ Yes ❑ No

Do you have any Drug Allergies: ❑ Yes ❑ No If yes, please list medication and reaction to medication:

_____

_____

_____

_____

Current Medications (including vitamins, herbal, and non-perscription medications):

_____

_____

_____

_____

_____

_____

Female Breast Health History Form

At what age did your menstral cycles begin? _____

If you no longer have menstral cycles, what age did you reach menopause? _____

Do you have any family members who had breast cancer? ❑ Yes ❑ No

If yes, what was their relationship to you? _____

Do you perform regular breast self exams? ❑ Yes ❑ No

If you perform routine BSE's, do you have any of the following:

❑ abnormal nipple discharge ❑ breast lumps

When your last mammogram? ❑ Never had one ❑ I have, the last one was on _____

Were the results normal? ❑ Yes ❑ No

(For Breast Reduction Patients Only)

What is your height? _____ What is your current weight? _____

What is your current bra size? _____ What is your desired breast size? _____

Doe you have any of the following symptoms:

❑ Neck pain ❑ Shoulder pain ❑ Back pain ❑ Shoulder grooving ❑ Breast pain

❑ Recurrent Rashes under your breasts ❑ Postural problems

If you suffer from any of the above symptoms, at what age did you first notice your breasts were excessively large and started causing symptoms? _____

Have these symptoms gotten worse recently? ❑ Yes ❑ No

If yes, how long ago did it start getting worse? _____

Does anything exacerbate or alleviate these symptoms? ❑ Yes ❑ No

If yes, what makes these symptoms better? _____

If yes, what makes these symptoms worse? _____

Do you currently wear a good supportive bra? ❑ Yes ❑ No How long does the bra last? _____

Have you received any treatment for these symptoms? ❑ Yes ❑ No

If you received treatment for your ailementes, which of the following have you undergone?

❑ Physical Therapy ❑ Chiropractic Treatments ❑ Narcotic Pain Medications

❑ Non-Narcotic Pain Medication ❑ Muscle Relaxants ❑ Rash Medications

Did you every have radiological studies of your neck/spine? ❑ Yes ❑ No Were the results normal? ❑ Yes ❑ No

If the results were abnormal, what were the abnormalities detected?

_____

_____

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Notice Of Privacy Practices Acknowledgement

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have a certain right to privacy regarding my protected health information. I understand that the information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations, such as quality assessment and physician certifications.

I have received, read, and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change it's Notice of Privacy Practice from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

_____ _____

Patient Name Patient's Signature

_____ _____

Relation to Patient Date

Revised 11/09