Aestique® Plastic Surgical Associates, Ltd.
Registration Form

PATIENT NAME (Last, First, Middle Initial):				Maiden Name	DATE:
Marital Status S - M - W - DIV - SEP	Date of Birth:	Age:	Sex:	Race: [ ] Caucasian [ ] Asian [ ] Hispanic [ ] Indian [ ] African American	
Street Address: [ ] Permanent [ ] Temporary		City State Zip		Home Phone:	
Patient's Employer:		Occupation: (Student []Part-time []Full-time)		Business Phone:	
Social Security Number:		Cell Phone Number and/or Pager Number		Carrier of Cell Phone Service:	
Emergency Contact:		Relationship:		Telephone Number:	

**Email will be used for most all communication from our office. It may also be used to keep you informed of all promotions, discounts, education, etc This information will NOT be shared.*

Email Address:

IF PATIENT IS A MINOR OR STUDENT PLEASE FILL OUT THIS SECTION

Mother's Name:	Full Address:	Home Phone Number:	Social Security Number:
Mother's Birth Date:	Mother's Employer:	Occupation:	Business Phone Number:
Father's Name:	Full Address:	Home Phone Number:	Social Security Number:
Father's Birth Date:	Father's Employer:	Occupation:	Business Phone Number:

INSURANCE (PLEASE PROVIDE A COPY OF INSURANCE CARD – FRONT & BACK)

PRIMARY	NAME OF INSURANCE	INSURANCE ADDRESS PHONE #	
	SUBSCRIBER ID #/CLAIM #	GROUP #	
	SUBSCRIBER	DATE OF BIRTH	RELATIONSHIP
	SUBSCRIBER ADDRESS		
	EMPLOYER	OCCUPATION	SOCIAL SECURITY #
SECONDARY	NAME OF INSURANCE	INSURANCE ADDRESS PHONE #	
	SUBSCRIBER ID #/CLAIM #	GROUP #	
	SUBSCRIBER	DATE OF BIRTH	RELATIONSHIP
	SUBSCRIBER ADDRESS		
	EMPLOYER	OCCUPATION	SOCIAL SECURITY#

PHARMACY INFORMATION:

Name of Pharmacy: _____ **Address:** _____

Phone: _____ **Fax:** _____ _____

If applicable: Date of ACCIDENT or INJURY_____ Due to : [ ] Work [ ] Auto [ ] Other

I request that payment of authorized insurance benefits be made to Aestique Plastic Surgical Associates, Ltd for any services furnished to me by that physician or supplier. I authorize the release of medical information (and/or photographs) about me needed to determine the benefits or the benefits payable for related services to my insurance company and its agents.

SIGNATURE: _____ **DATE:**_____

Revised: 04/12/13

Aestique® Plastic Surgery & MediSpa
Medical History

Patient Name: _____ D.O.B: _____ Age: _____

Stated Height: _____ Stated Weight: _____ Blood Pressure: _____

Referring Physician (Address & Phone): _____

Primary Care Physician (Address & Phone): _____

How did you hear about us? _____

Past Medical History: (Please circle yes or no – ***MUST BE WITHIN LAST YEAR***.)

Neurological:	Migraine/ Headache	Yes	No
	Glaucoma	Yes	No
Pulmonary:	Asthma	Yes	No
	Deep Vein Thrombosis	Yes	No
	Sleep Apnea	Yes	No
	Lung Cancer/TB	Yes	No
	Emphysema / COPD	Yes	No
	Pulmonary Embolism	Yes	No
Cardiac:	High Blood Pressure	Yes	No
	Heart Attack	Yes	No
	Heart Surgery	Yes	No
	Coronary Artery Disease	Yes	No
	Irregular Heart Beat	Yes	No
	Atrial Fibrillation	Yes	No
Gastrointestinal:	Reflux / Heartburn	Yes	No
	Hiatal Hernia	Yes	No
Liver:	Liver Disease / Cirrhosis	Yes	No
	Hepatitis	Yes	No
Gyn/Breast:	Breast Cancer/ Mastectomy	Yes	No
	Are you pregnant?	Yes	No
	Are you breast feeding?	Yes	No
	Number of pregnancies:		
	Number of births:		
	Last Mammogram:		
Skin:	Cancer	Yes	No
	Eczema	Yes	No
	Psoriosis	Yes	No
	Cold Sores	Yes	No
Hair	Hair thinning	Yes	No

Endocrine:	Diabetes	Yes	No
	Hypoglycemia	Yes	No
	Thyroid Disease	Yes	No
Renal/Genitourinary	Kidney Disease	Yes	No
	Kidney Failure	Yes	No
Vascular:	Aneurysm	Yes	No
	Poor Circulation	Yes	No
Rheumatology	Rheumatoid Arthritis	Yes	No
	Osteoarthritis	Yes	No
	Lupus / Scleroderma	Yes	No
	Fibromyalgia	Yes	No
Hematology / Infectious Disease:	Anemia	Yes	No
	Bleeding Tendencies	Yes	No
	Hemophilia	Yes	No
	Sickle Cell	Yes	No
	Low Platelets	Yes	No
	Thrombocytopenia	Yes	No
	Sexually Transmitted Disease	Yes	No
	HIV / AIDS	Yes	No
Musculoskeletal:	Artificial joint / prosthesis	Yes	No
	Multiple Sclerosis	Yes	No
Cancer/ Malignancy:	Location:		
	Chemotherapy	Yes	No
	Radiation	Yes	No
	Date finished tx:		
Psychiatric:	Depression / Anxiety	Yes	No
	ADHD / Bi-Polar	Yes	No
	Eating Disorder	Yes	No
	Schizophrenia	Yes	No

Aestique® Plastic Surgery & MediSpa
Medical History

Past Surgical History: **(**Please list name of procedure and date.)

1._____ 2._____

3._____ 4._____

5._____ 6._____

Medications: (Please list all current medications and dosages.)

1._____ 5._____

2._____ 6._____

3._____ 7._____

4._____ 8._____

Drug Allergies: YES / NO **List**:_____

Reactions:_____

Do you have an allergy to Latex? YES NO
Do you have an allergy to Codeine? YES NO
Have you ever been on Accutane? YES NO
If yes, when: _____

Social History:

1. Occupation: _____
2. Single/Married/Separated/Divorced (circle one)
3. Have you ever used tobacco?: Yes No
   If yes, # of packs per day?:_____ for # of years?:_____
   If you quit using tobacco, when?:_____
4. Do you drink alcohol?: Yes No
   How much: _____ How often?:_____
5. Do you use recreational drugs?: Yes No
   Type:_____

Family History: Please list any family medical history/problems.

	Age	Diseases	Cause of Death
Father	_____	_____	_____
Mother	_____	_____	_____

ACKNOWLEDGEMENT:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform Aestique Plastic Surgical Associates of any changes in my medical status. I also authorize the health care staff to perform the necessary services I may need.

Patient Signature:_____ **Date:**_____

Revised: 10/28/20

CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT, OR HEALTHCARE OPERATIONS

This Consent applies to the following corporations contained within *Aestique® Medical Center*: *Aestique® Ambulatory Surgical Center, Inc., Aestique Plastic Surgical Associates, Ltd., Aestique®Executive Healthcare, Inc.,* and *Aestique® Executive Healthcare, Inc.* doing business as *The Spa at Aestique® Medical Center.* The name *"Aestique® Medical Center"* will be used throughout this Consent to pertain to any one of the above healthcare corporations. This Consent also applies to *Aestique® Medical Center's* Anesthesia Providers.

I understand that as part of my healthcare, *Aestique® Medical Center* and *Aestique® Medical Center's* Anesthesia Providers and maintain health records describing my health history. I understand that the information may be used as:

1. a basis for planning my care and treatment;
2. a means of communication among many health professionals who contribute to my care;
3. a means by which third-party payors can verify that services billed were actually provided; and
4. a tool for routine health care operations such as assessing quality and reviewing the competence of health care professionals.

I hereby consent to *Aestique® Medical Center's* and *Aestique® Medical Center's* Anesthesia Providers' use and disclosure of my individually identifiable health information for the purposes listed above and other purposes relating to my treatment, the payment of my health care, and other health care operations of *Aestique® Medical Center* and *Aestique® Medical Center's* Anesthesia Providers. In addition, I acknowledge that I received on the date indicated below a copy of the Notice of Privacy Practices, which describes the obligations of *Aestique® Medical Center* and *Aestique® Medical Center's* Anesthesia Providers regarding its use and disclosure of my individually identifiable health information and my rights regarding this information. *Aestique® Medical Center* and *Aestique® Medical Center's* Anesthesia Providers have developed a joint Notice of their Privacy Practices and are using the joint consent form in order to simplify the administrative process for patients. However, *Aestique® Medical Center's* Anesthesia Providers and *Aestique® Medical Center* are separate legal entities. They are each separately required to comply with state and federal law. They must each comply with the Notice and this Consent Form. *Aestique® Medical Center* and *Aestique® Medical Center's* Anesthesia Providers are not responsible for the other's failure to comply with the notice or this Consent Form. I also understand that *Aestique® Medical Center* and *Aestique® Medical Center's* Anesthesia Providers reserve the right to change its notice and practices. If the notice is changed, I can obtain a revised copy by asking the Receptionist. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or other healthcare operations and that the healthcare corporation I am accessing is not required to agree to the restrictions requested. If the entity does agree to such restrictions, however, the entity must comply with such restrictions.

_____ (Initial) I request the following restrictions to the use or disclosure of my health information:

_____

_____

Effective Date of Notice: February 1, 2004

X_____ Date:_____

Signature of patient or patient's representative

Printed name of patient's representative: _____

Relationship to patient: _____

AESTIQUE®
Live Life Counterclockwise®

Aestique® Plastic Surgical Associates, Ltd.

CONSENT TO COMMUNICATE

Patient Name: _____

Please mark the ways that you consent to us communicating with you:

Method	OK to leave voicemail	Ok to leave message with another person	Preferred contact method(s)	Best time to call
Call Work Phone	☐ Yes ☐ No	☐ Yes ☐ No		
Call Cell Phone	☐ Yes ☐ No	☐ Yes ☐ No		
Call Home Phone	☐ Yes ☐ No	☐ Yes ☐ No		
Send Email				
Email Appt Reminders	☐ Yes ☐ No			
Email Marketing Info	☐ Yes ☐ No			
Send Regular Mail	☐ Yes ☐ No			
Send Text Page				
Ok for appt reminder?	☐ Yes ☐ No			
Ok for special offers?	☐ Yes ☐ No			

If it's ok to message with another person, please list them:

Name	DOB	Relationship	OK to Release Results	Any Comments
			☐ Yes ☐ No	
			☐ Yes ☐ No	

Signature: _____ Date: _____