Office Information Sheet/ Patient Information

On behalf of our providers and staff, we would like to take this opportunity to welcome you to Devenu. Thank you for your kind cooperation in filling out our information sheet.

Patient Information

Full name: ____ DOB: ___________
Address: ____
City: _________________________ State: ______ Zip: ________ Sex: Male _____ Female _______
Home phone: (____)_____________ Work phone: (____)__________ Cell phone: (___)____________
SSN:_______________________________________Marital Status (please circle): S M W D
Employer/School: __________________________ Occupation: _______________________
To receive notification of special offers please provide your e-mail address here:
____
To contact me please call: (check all that apply) home ___ work ___ cell ___

Person Financially Responsible

(If same as above please skip this section)
Name: ___________________________ Relationship to patient: _______________________
Address: ____________________________ City: ___________ State: _____ Zip: ________
SSN: ________________________________ Employer: ______________________________
Home phone: (____)_____________ Work phone: (___)___________ Cell phone: (___)___________

Emergency Contact

Name: _________________________________ Relationship: _________________________
Home Address: _________________________City: ___________ State: _____ Zip: _______
Home phone: (____)_____________ Work phone: (___)___________ Cell phone: (___)___________
Please list the name of your Primary Care Physician:________________________________

Referral Information

How did you hear about us? (please circle) newspaper internet television magazine friend physician
other: ___________________________

Release of Information

I understand that I am financially responsible for all charges whether or not paid by my insurance. I understand that most cosmetic procedures will not be covered by my insurance.

I have also been advised that this office requires a 24-hour prior notice on all appointment cancellations. With failure to notify Devenu staff I understand I will be charged a set fee of $100 dollars.

Signature: ____ Date: ________________________

Patient History

Please list any medications, including prescription or over-the-counter medicines or vitamins that you are taking:

1. ______________________ Reason for taking: ______________________
2. ______________________ Reason for taking: ______________________
3. ______________________ Reason for taking: ______________________
4. ______________________ Reason for taking: ______________________
5. ______________________ Reason for taking: ______________________
6. ______________________ Reason for taking: ______________________

Please list any medication and/or environmental allergies you have and what reaction you will have with each allergy: ____
____

Are you allergic to latex?	Yes	No	Are you allergic to tape?	Yes	No
Do you smoke cigarettes?	Yes	No	Are you pregnant?	Yes	No
Do you chew tobacco?	Yes	No	Are you planning on Pregnancy?	Yes	No
Do you drink alcohol?	Yes	No	Are you breast feeding?	Yes	No
Do you use recreational drugs?	Yes	No			
Do you drink caffeine?	Yes	No			

Do you go tanning in a tanning bed or booth? Yes No If yes, how often? ____________
When was the last time you tanned or were out in the sun for tanning purposes? ____________

Have you ever had any of the following:

Retin A?	Yes	No	When:________	Complications:	Yes	No
Botox?	Yes	No	When:________	Complications:	Yes	No
Filler?	Yes	No	When:________	Complications:	Yes	No
Laser Hair Removal?	Yes	No	When:________	Complications:	Yes	No
Sclerotherapy? (leg veins)	Yes	No	When:________	Complications:	Yes	No
IPL (or BBL)?	Yes	No	When:________	Complications:	Yes	No

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medical rejuvenation center

Patient History (cont.)

Liposuction?	Yes	No	When:____________	Complications:	Yes	No
Lipodissolve?	Yes	No	When:____________	Complications:	Yes	No
Coolsculpting?	Yes	No	When:____________	Complications:	Yes	No
Hormone Therapy?	Yes	No	When:____________	Complications:	Yes	No
Chemical Peel?	Yes	No	When:____________	Complications:	Yes	No
Laser Peel?	Yes	No	When:____________	Complications:	Yes	No
Microdermabrasion?	Yes	No	When:____________	Complications:	Yes	No
Skin diseases?	Yes	No	When:____________	Complications:	Yes	No
Hyperpigmentation? (Darkening of the skin)	Yes	No	When:____________	Complications:	Yes	No
Hypopigmentation? (Lightening of the skin)	Yes	No	When:____________	Complications:	Yes	No

Skin

Have you ever been treated for acne?	Yes	No
Have you ever had skin cancer?	Yes	No
Do you have problems healing?	Yes	No

Are you prone to cold sores?	Yes	No	Do you have eczema or psoriasis?	Yes	No
Do you have genital herpes?	Yes	No	Do you have rosacea?	Yes	No
Do you develop keloid scars?	Yes	No	Do you have sensitive or allergic skin?	Yes	No

Do you have now, or have you ever had diseases or conditions of:

Artificial Joint	Yes	No	Hepatitis	Yes	No
Autoimmune Disease	Yes	No	High Blood Pressure	Yes	No
Blood Clots	Yes	No	HIV or AIDS	Yes	No
Phlebitis (Inflammation of the Vein)	Yes	No	Irregular Heart Beat	Yes	No
Convulsions or Epilepsy or Seizures	Yes	No	Lung Disease or Asthma	Yes	No
Diabetes	Yes	No	Pacemaker	Yes	No
Depression/Anxiety	Yes	No	Cancer	Yes	No
Heart Attack	Yes	No	Thyroid	Yes	No

Patient History (cont.)

Past Surgical History:

Date: ____/____/____ Procedure: ____
Date: ____/____/____ Procedure: ____
Date: ____/____/____ Procedure: ____

Pregnancy: #__________ Delivery: #__________

Family History

Member Afflicted:

Heart Disease ____
Hypertension ____
Stroke ____
Cancer ____
Diabetes ____
Other ____
None ____

Nutritional/Natural Supplements

Please identify and list the products you are currently using:
Vitamins (single or multiple)____
Minerals (Calcium, magnesium, etc.)____
Nutrition/Protein Supplements (protein powders, amino acids, etc)_________________________
____
Others____