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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.

Today's Date: _____

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: _____
Email Address:_____
To contact me please call: (check all that apply) home __ work __ cell __
May we leave a voicemail? Yes No

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: (___)_____

Missed/Canceled Appointments: We would appreciate the courtesy of a call if you are unable to keep an appointment. Please notify our office at least 24 hours in advance if you need to cancel or reschedule. We reserve the right to charge you a $25 fee when not given a 24 hour advance notice.

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: _____

Whom may we thank for referring you to our office? _____

Patient Signature_____

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.**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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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_____

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Today's Date:_____

Printed Name: _____ Patient DOB:_____

Acknowledge of receipt of Devenu Medical Rejuvenation Center's Notice of Privacy Practices

I have been given a copy of Devenu Medical Rejuvenation Center's Notice of Privacy Practices for Protected Health Information. I understand that Devenu Medical Rejuvenation Center has the right to change this Notice of Privacy Practices at any time. I may obtain a current copy at Devenu Medical Rejuvenation Center. The undersigned does herby acknowledge receipt of Devenu Medical Rejuvenation Center's Notice for Protected Health information.

Dated this _____ day of _____, 20_____.

_____
Patient Signature

CONSENT TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION FOR TREATMENT, PAYMENT, AND HEALTHCARE OPERATIONS

I give Devenu Medical rejuvenation Center to disclose personal health information about me to the following friends and/or family members.

_____ relationship to patient: _____

_____ relationship to patient: _____

_____ relationship to patient: _____

_____ relationship to patient: _____

_____ relationship to patient: _____

I reserve the right to add or delete names to this list at any time, which I will specify in writing.

_____ _____
Signature of patient/responsible party Date

For office use only: Initial for completeness and authorization _____