Patient Information

In order to provide you with the most appropriate treatments, we ask that you complete the following questionnaire. All information is strictly confidential.

Please Print: **Today's Date:** ______/______/________

First Name: __________________________________ **MI:** ______ **Last Name:** _____________________________________

Birth Date: ______/______/________ **Occupation:** ____________________________________ **Present Weight:** ________

Street Address: ____

City: ____ **State:** ___________ **Zip:** ____________________________

Mailing Address: ____

City: ____ **State:** ___________ **Zip:** ____________________________

Cell Phone #: (______) ________-________ **Home Phone #:** (______) ________-_________

Email Address: ____**Work Phone#:** (______) ______-________

Marital Status: (Please Circle) Married Single Divorced Widowed

Spouse/Significant Other's Name: __________________________________ **Phone #:** (______) ________-_________

Emergency Contact Name: ____ **Phone #:** (______) _________-__________

How did you hear about us? ____

Referring Friends Name: ____

I am here for: (Please check all that apply)

_____ Anti-Aging _____ Hair Removal _____Laser Treatments

_____ Botox/Fillers _____ Hormone Replacement _____Skin Care

_____ Consultation _____ Injections _____ Weight Loss

General Health Information

Please mark each health issue that applies to YOU:

X	Condition/Age of diagnosis	X	Condition/Age of Diagnosis	X	Condition/Age of Diagnosis
	Asthma/Lung Disease		Frequent Cold Sores		Paralysis
	Auto Immune Disease		Glaucoma		Pulmonary Embolus
	Blood Clotting Abnormalities		Headaches/Migraine		Rheumatic Fever
	Blood Transfusion		Heart Issues		Seasonal Allergies
	Cancer (type)		Heart Murmur		Sinus Trouble
	Confusion/Depression		Hepatitis/Liver Disease		Skin Disease/Lesions
	Connective Tissue Disorder		Herpes		Thyroid Disorder
	Convulsions		High Blood Pressure		TMJ
	Defibrillators		HIV/AIDS		Varicosities/Phlebitis
	Diabetes		Hormone Imbalance		Other
	Digestive Disturbances		Keloid Scarring		Other
	Diverticulitis		Kidney Failure		Other
	Emotional/Psychiatric		Loss of Sleep		
	Epilepsy		Lupus		
	Forgetfulness		Mitral Valve Prolapse		

1. Are you currently under the care of a physician/Dermatologist? Yes No

If so for what condition? ______________________________

2. Do you have a history of erythema abigne? Yes No

(A persistent skin rash produced by prolonged or repeated exposure to moderately intense heat or infrared irritation)

3. Do you have any metal or artificial joints? Yes No

If so please explain: ______________________________

4. Have you ever been diagnosed with any type of cancer? Yes No

If so, when ______________ What type of cancer? ______________

5. Do you use tobacco? Yes No

If yes, how long? ______________ How much per day?______________

6. Do you drink alcoholic beverages? Yes No

If yes, how often? ______________________________

Do you smoke marijuana or use other recreational drugs? **Yes** **No**

Please list all medications that you are currently taking. Please include any Hormone Replacement Therapies, herbal or over the counter supplements and any topical medications (i.e. Tretinoin, Retin-A, AndroGel, hormonal patches or creams). ____

____

When was the last time you used it? ____

Please list any surgeries or hospitalizations: ____

____

Other medical history for yourself or family: ____

____

Please list any medications that you are allergic to and the type of reaction. ____________________

____

Have you ever had an allergic reaction to the following?

_____	**Aspirin**	______	**Insect Bites/Stings**	______	**Nuts**
_____	**Benzoyl Peroxide**	______	**Latex**	______	**Peanuts**
_____	**Garlic**	______	**Lavender**	______	**Pumpkin**
_____	**Hydro-Cortisone**	______	**Lidocaine**	______	**Salicylic Acid/ (Aspirin)**

Patient's Name (Print): ____

Patient's Signature: ____ **Date:** _____/_____/_______

Practitioners Signature: ____ **Date:** _____/_____/_______

Photo Consent

This consent form authorizes Back To 30™ to use any photographs taken for marketing, medical education, teaching or research. Under no such circumstances will any publications or material bear your name or identifying information. Your refusal to consent to the use of these photographs for marketing, medical education, teaching or research will in no way influence your treatment.

I ________________________________, understand the photographs taken of me shall be used for medical records and if in the judgment of the medial health care professional, marketing, medical research, education or science. Any photography and/or information relating to my case may be published and republished, either separately or in conjunction with each other, in professional journals or Back to 30 website, in all marketing, and for medical education, knowledge or research.

I waive the rights that I may have to any claims for payment of royalties in connection with any exhibition, televising or publication of these photographs.

I release and hold harmless the clinic, staff and consultants from any liability in connection with the use of such materials.

I understand that the foregoing consent is subject to the following limitation: Under no circumstances will any such publication, film photograph, video tape or material exhibited contain my name or other personal protected information unless voluntarily disclosed by me.

Patient Name (Print): ____

Patient Signature: ____ Date: ______/______/________

Professional Signature: ____ Date: ______/______/________

OR

Please sign one area only (upper or lower)

I ____________________________________, only consent for my pictures to be used for medical purposes. They are only for my file and to be kept only to review and monitor my progress.

Patient Name (Print): ____

Patient Signature: ____ Date: ______/______/________

Professional Signature: ____ Date: ______/______/________

Consent for Use of Disclosure of Health Information

Our Privacy Pledge

We are very concerned with protecting your privacy. While the law requires us to give you this disclosure, please understand that we have, and always will, respect the privacy of your health information.

There are several circumstances in which we may have to use or disclose your health care information:

- We may have to disclose your health information to another health care provider or a hospital if it is necessary to refer you to them for the diagnosis, assessment, or treatment of your health condition.
- We may have to disclose your health information and billing records to another party if they are potentially responsible for the payment of your services.
- We may need to use your health information within our practice for quality control or other operation purposes.

We have a more complete notice that provides a detailed description of how your health information may be used or disclosed. You have the right to review that notice before you sign this consent form (§164.520). We reserve the right to change our privacy as escribed in that notice. If we make a change to our privacy practices, we will notify you I writing when you come in for treatment or by mail. Please feel free to call us at any time for a copy of our privacy notices.

Your Right to Limit Uses or Disclosures

You have the right to request that we do not disclose your health information to specific individuals, companies or organizations. If you would like to place any restrictions on the use or disclosure or your health information; please let us know in writing. We are not required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

I have read your consent policy and agree to its terms. I am also acknowledging that I have received a copy of this notice (if desired?)

Patient Name (Print): ____

Patient Signature: ____ **Date:** ______/______/________

Representative Signature: ____ **Date:** ______/______/________