

Aesthetic Specialty Centre
770-393-9000 / 706-467-6500

PATIENT REGISTRATION			DATE _____
NAME		AGE	DATE OF BIRTH
ADDRESS		E-MAIL ADDRESS	
CITY	STATE	ZIP	SS#
PHONE (HOME)	(CELL)	(WORK)	OCCUPATION/EMPLOYER
SPOUSE'S NAME			OCCUPATION/EMPLOYER
IF UNDER 18 PARENT/GUARDIAN			
EMERGENCY CONTACT (OTHER THAN SPOUSE)		RELATION	ADDRESS
			PHONE
<i>Please check the areas you would like to discuss</i>			
<input type="checkbox"/> Eyelids	<input type="checkbox"/> Ear Reshaping	<input type="checkbox"/> Laser Resurfacing	<input type="checkbox"/> Skin Care
<input type="checkbox"/> Facelift	<input type="checkbox"/> Liposuction	<input type="checkbox"/> Peel/Microdermabrasion	<input type="checkbox"/> Massage Therapy
<input type="checkbox"/> Nose	<input type="checkbox"/> Botox	<input type="checkbox"/> Laser Hair Removal	<input type="checkbox"/> Make-Up
<input type="checkbox"/> Chin / Cheeks	<input type="checkbox"/> Injectable Fillers	<input type="checkbox"/> Scar Revision	<input type="checkbox"/> Doctor's visit
<input type="checkbox"/> Lips	<input type="checkbox"/> Veins	<input type="checkbox"/> Moles, etc.	<input type="checkbox"/> Breast Surgery
<input type="checkbox"/> Tummy Tuck	<input type="checkbox"/> Body Lift	<input type="checkbox"/> Gluteal Augmentation	<input type="checkbox"/> Other
Referred by:			
<input type="checkbox"/> Doctor (name _____)	<input type="checkbox"/> Attended one of your lectures		
<input type="checkbox"/> Friend (name _____)	<input type="checkbox"/> Telephone Yellow Pages		
<input type="checkbox"/> Family (name _____)	<input type="checkbox"/> Other _____		
Pharmacy Name & Number: _____			
Insurance Benefits:			
PRIMARY		SECONDARY	
Insurance Company _____		Insurance Company _____	
Name of Policy Holder _____		Name of Policy Holder _____	
Policy Holder's Date of Birth _____		Policy Holder's Date of Birth _____	
Relationship of patient to Policy Holder _____		Relationship of patient to Policy Holder _____	
<p>I authorize the release of medical information to my primary care or referring physician, to consultants if needed and as necessary to process insurance claims, insurance applications and prescriptions. I also authorize direct payment of surgical / medical benefits to Aesthetic Specialty Centre.</p> <p>Payment is required for all services at the time they are rendered unless you are in a plan in which we participate. For those patients, applicable copayments and deductibles will be collected. I understand that I am financially responsible for any balance not covered by my insurance.</p> <p>Should the account become delinquent and fall into collections I will be responsible for any additional collections agency charges along with the balance owed to Aesthetic Specialty Centre</p>			
Patient or Responsible Party Signature _____			Date ____ / ____ / ____

Patient Medical History

Patient Name: _____ **Pt. #:** _____ **Date:** _____

In order to be thoroughly familiar with your individual needs, we request that you complete this form accurately.

This is part of your Medical Record and is kept absolutely confidential!

Allergies: (Latex, Lidocaine, Epinephrine, Medication) _____

Medications: _____

Have you had any reaction to injections of a local anesthesia or general anesthesia? Yes No

Are you taking any of the following? (Please circle): Aspirin, Advil, Aleve, Ibuprofen, Motrin, Nuprin, Vitamin E

Date of last physical: _____ Physician: _____

List previous surgeries you have had, dates and attending Physician: _____

Have you had any type of implants? Yes No What type? _____ When? _____

Have you had an EKG or Chest X-Ray in the past year? Yes No

Have you been on Accutane within the past 12 months? Yes No

General Health History: Have you been or are you now under treatment for any of these major medical conditions?
Please circle either Yes or No.

Anemia	Yes	No	High Blood Pressure	Yes	No	Psoriasis	Yes	No
Arthritis	Yes	No	HIV	Yes	No	Eczema	Yes	No
Autoimmune	Yes	No	Hives	Yes	No	Thyroid Disorder	Yes	No
Lupus	Yes	No	Keloids/Scars	Yes	No	Endocrine Disorder	Yes	No
Bleeding Disorders	Yes	No	Migraines	Yes	No	Skin Diseases	Yes	No
Blood Clots	Yes	No	Pacemaker	Yes	No	Skin Cancer	Yes	No
Cancer	Yes	No	Defibrillator	Yes	No	Type _____		
Diabetes	Yes	No	Headaches	Yes	No	Sun Allergy	Yes	No
Eye Problems	Yes	No	Asthma	Yes	No	Neurological Disorder	Yes	No
Hay Fever	Yes	No	Bronchitis	Yes	No	Seizures	Yes	No
Heart Arrhythmia	Yes	No	Lung Disease	Yes	No	Kidney Diseases	Yes	No
Heart Murmur	Yes	No	Emphasema	Yes	No	Urinary Tract Diseases	Yes	No
Heart Disease	Yes	No	Psychiatric Disorders	Yes	No	Gastrointestinal Disease	Yes	No
Hepatitis	Yes	No	Recent Weight Gain/Loss	Yes	No	History of Melanoma	Yes	No
Herpes/Cold Sores	Yes	No	Rheumatic Fever	Yes	No	History of Atypical Moles	Yes	No

Female:

Currently Pregnant Yes No Menstrual Irregularity Yes No Birth Control Yes No

Please elaborate on or add any medical disorders and problems not mentioned above: _____

(Dentures, partials, caps, bonding, loose or chipped teeth; hiatal hernia, reflux, ulcers, rectal bleeding, sleep apnea, c-pap machine, limitation devices, mobility, visual, auditory language.)

Do you smoke? Yes No How much/often _____

Do you drink alcohol? Yes No How much/often _____

Do you drink caffeine? Yes No How much/often _____

Do you exercise regularly? Yes No How much/often _____

Recreational Drug Use/Diet Pills? Yes No How much/often _____

Family History: Have any members of your immediate family had treatment for any of the following?

Arthritis	Yes	No	Diabetes	Yes	No	Hay Fever	Yes	No
Asthma	Yes	No	Eczema	Yes	No	Psoriasis	Yes	No
Cancer	Yes	No	Hair Loss	Yes	No	Skin Cancer	Yes	No

Patient Signature

Date

Physician Signature

MA Signature

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Patient Consent for Use and Disclosure of Protected Health Information

With my consent, Aesthetic Specialty Centre may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to Aesthetic Specialty Centre's Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Aesthetic Specialty Centre reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Aesthetic Specialty Centre Privacy Officer at 1825 Old Alabama Road, Roswell, GA 30076.

With my consent, Aesthetic Specialty Centre may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others.

With my consent, Aesthetic Specialty Centre may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements.

With my consent, Aesthetic Specialty Centre may e-mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that Aesthetic Specialty Centre restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to Aesthetic Specialty Centre's use and disclosure of my PHI to carry out TPO. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, Aesthetic Specialty Centre may decline to provide treatment to me.

Cancellation Policy

Consultation - 48 hour cancellation notice, otherwise \$200 fee

Dermatology – 24 hour cancellation notice, otherwise \$35 fee

Cosmetic – 24 hour cancellation notice, otherwise \$50 fee

Signature of Patient or Legal Guardian

Patient's Name

Date

Print Name of Patient or Legal Guardian

Dermatology - In order to follow the progress of a treatment or to watch suspicious areas of concern, this is an authorization to have your picture taken.

Patient Signature

Date

