REJUVA
MEDICAL AESTHETICS

Date: _____ **Email:**_____ ACCT.#:_____

To ensure proper communication with your doctor, I authorize email communication with me: _____**initials**

PATIENTS PERSONAL INFORMATION:

Name: _____ **DOB**: ____/_____/_____ **Age**: _____

Mailing Address: _____ (Apt # _____)

City: _____ **State/Country**: _____ **Zip**: _____

Primary Telephone: (_____) _____ **Secondary Telephone**: (_____) _____

Sex: ☐ Female ☐ Male **Marital Status**: ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

PATIENT REFERAL INFORMATION:

☐ TV ☐ Internet ☐ Other/Define: _____ ☐ Referred by: _____

EMERGENCY CONTACT:

Name: _____ Phone: (_____)_____ Relationship: _____

Primary Physician Name: _____ Phone: (_____) _____

Please check all that interests you:

☐ Facelift, Neck Lift, Brow Lift
☐ Eyelid Surgery
☐ Nose Surgery (cosmetic & breathing)
☐ Facial Contouring, Implants, Fat Grafting
☐ Prominent Ear
☐ Breast Augmentation
☐ Scar Revision
☐ Liposuction
☐ Anti-Aging, Prevention Skincare
☐ Acne Treatments
☐ Platelet Rich Plasma
☐ Eyelash Enhancement
☐ Other:

☐ Botox, Dysport, Xeomin Injections
☐ Dermal Fillers (Juvederm, Restylane, Radiesse, Belotero, etc.)
☐ ThermiSmooth & ThermiTight
☐ Laser Vein Removal
☐ Laser Treatments to Improve Skin Quality
☐ Laser Therapy to Improve Pigmentation or Spots
☐ Laser Therapy for Skin Tightening or Firming
☐ Medical Facials and Peels
☐ Sun Damage Repair
☐ Scar Treatment
☐ Platelet Rich Fibrin
☐ Not sure, need consultation

_____

Please list all known medical allergies: _____
Please list current medications (including Vitamins & Supplements):
_____
_____

Is there anything else about your medical history that might be helpful for the doctor to know?

_____

I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in the above information. I authorize the release of any medical information necessary to process an insurance claim.

PATIENT SIGNATURE :_____ DATE: _____