PLEASE COMPLETE BOTH PAGES OF THIS FORM COMPLETELY

Today's Date________________

Patient's Full Name (Last) ______________________________ (First)____________________________(MI)__________

SSN #____________________________ Date of Birth_______/______/______ Age_______Sex_____F______M

Address____City_____________________State__________ZIP__________

Home # (_______) _________________________ OK to leave Message _____Yes______NO
Work # (_______) _________________________ OK to leave Message______Yes______NO
Cell # (________) __________________________OK to leave Message______Yes______NO

EMAIL ADDRESS: ____

Marital Status: _____ Married ______Single ______Separated_______Divorce_______Widow(er)

Patient's Employer__________________________________ Position __________________________________

Spouse's Name___________________________________ Spouse's employer_________________________________

Has this office seen any member of your family? ________Yes ________No
If Yes, Who? ______________________________________

Nearest Relative, not living with you: ____
Relationship: _________________________ Address: _______________________________________
City: ________________________ State: ____________________ Phone: __________________________

How were you referred to this office?
Physician, Who: ______________________
Relative, Who: _______________________
General Reputation: ___________________
Other: ______________________________
Friend, Who: ______________________
Media, Who: ______________________
Internet: __________________________

Person responsible for the payment (Guarantor):____________________________________
Relationship to Patient: _________________________________
Address: ____
Phone #: _____________________________________ Social Security #: ________________________________

WOULD YOU BE INTERESTED IN APPEARING ON TELEVISION? _________Yes ___________No

WOULD YOU LIKE TO RECEIVE PROMOTIONAL MATERITALS THROUGH EMAIL? _____________Yes __________No

MEDICAL INFORMATION
(PLEASE BE ACCURATE)

Specific reason for which you are being seen today: ( ) Skin rejuvenation, face & body
( ) Stimulate hair follicles, Regrow hair
( ) IV Infusion, Wellness & Vitality
( ) Regenerative Medicine, scars, & damaged skin
( ) O-Shot, vaginal rejuvenation
( ) Other

Have you seen any other Doctor for this reason? _____Yes ______NO If Yes, Who: ______________________________

Please list all surgical procedures you have undergone:

Procedure:	Date:	Surgeon:
____	_______________	________________________________
____	_______________	________________________________
____	_______________	________________________________

Any Complication? ________Yes __________No If YES, Please explain: ____

Please list all Drug Allergies: ____

Please list all Environmental Allergies: ____

Do you Smoke? _____Cigarettes _____Marijuana _____Cigars _____Patch ______Chew Tobacco, How Much_________

List all medications you are currently taking and medical condition:

Drug:	Medical Condition:	Drug:	Medical Condition:
______________	___________________________	____________________	_________________________
______________	___________________________	____________________	_________________________
______________	___________________________	____________________	_________________________

What is your general state of health? _________Good ____________Fair ____________Poor
Height ________________ Weight ____________________

Have you ever tested positive for HIV: _______Yes ________ No Hepatitis C: _________Yes _________ No

Please list any medical problems, past and present and briefly specify the treating Physician:
____

Do you have a fear of Medical Procedures: _______ Yes ______ No,

If Yes, Indicate your degree of fear (1= no fear 10= very fearful) 1 2 3 4 5 6 7 8 9 10