NATURALLY YOU
MED SPA

PATIENT REGISTRATION FORM

First Name_____ **Last Name**_____

Address_____

City_____ **State**_____ **Zip**_____

Cell Phone_____**Home Phone**_____

Email Address_____

Date of Birth_____**Age**_____ **Sex (M) (F)**

Occupation_____ **Employer**_____

Drivers License #_____

Marital Status: S( ) M( ) W ( ) D( ) Social Security#_____

Emergency Contact _____ **Phone**_____

How Did You Hear About Us: _____

Have you had any other Cosmetic Procedures? Please List:

_____

Have you discussed this with your: ___Spouse ___Family ____Friends

When are you planning on having your procedure done _____

How will you pay for the services rendered? Cash____ Credit Card_____

This information is accurate and true to the best of my knowledge.

Signature_____**Date**_____

All information will be kept confidential.

PATIENT REGISTRATION FORM (cont)

Have you ever had or do you now have any of the following conditions: (circle Y or N)

Glaucoma or Blurry vision	**(Y)**	**(N)**	**Recurrent Severe Dizziness**	**(Y)**	**(N)**
Severe headaches	**(Y)**	**(N)**	**Chronic Sinus Problems**	**(Y)**	**(N)**
Asthma	**(Y)**	**(N)**	**Shortness of breath**	**(Y)**	**(N)**
Chest Pain	**(Y)**	**(N)**	**Heart Problems**	**(Y)**	**(N)**
High Blood Pressure	**(Y)**	**(N)**	**Rheumatic Fever**	**(Y)**	**(N)**
Abdominal Problems	**(Y)**	**(N)**	**Blood in bowels**	**(Y)**	**(N)**
Kidney/Bladder Problems	**(Y)**	**(N)**	**Blood in Urine**	**(Y)**	**(N)**
Bleeding disorder,Bruising	**(Y)**	**(N)**	**Seizures**	**(Y)**	**(N)**
Are you Pregnant	**(Y)**	**(N)**	**Menstrual Disorder**	**(Y)**	**(N)**
Abnormal lump/node	**(Y)**	**(N)**	**Problems with Bones/Joints**	**(Y)**	**(N)**
Hepatitis	**(Y)**	**(N)**	**Tuberculosis**	**(Y)**	**(N)**
Venereal Disease	**(Y)**	**(N)**	**Cancer**	**(Y)**	**(N)**
Diabetes	**(Y)**	**(N)**	**Chronic skin condition**	**(Y)**	**(N)**
Emotional problems	**(Y)**	**(N)**	**Psychiatric treatment**	**(Y)**	**(N)**
Problems with anesthesia	**(Y)**	**(N)**	**Complication after surgery**	**(Y)**	**(N)**
Blood Clots	**(Y)**	**(N)**	**Unsatisfactory medical results**	**(Y)**	**(N)**

Other_____

_____

_____

PATIENT REGISTRATION FORM (cont)

Are you *ALLERGIC* to any drugs?_____

How is your general health?_____ Current weight_____

Are you under a doctors care?_____

List all medications you are currently taking:

Prescription_____

Non Prescription_____

Vitamins and Herbs_____

Do you smoke?_____If yes how much per day/week?_____

Do you drink alcoholic beverages?_____If yes how much?_____

Have you or do you use recreational drugs?_____If yes, list:_____

OPERATIONS/HOSPITALIZATIONS **MAJOR ILLNESSES/INJURIES**

_____ _____

_____ _____

_____ _____

Are you HIV positive? _____

THE ABOVEINFORMATION IS ACCURATE AND TRUE TO THE BEST OF MY KNOWLEDGE

Patient Signature_____ Date_____

REVIEWED BY_____ Date_____

REVIEWED BY_____ Date_____

REVIEWED BY_____ Date_____

REVIEWED BY_____ Date_____

PATIENT REGISTRATION FORM (cont)

Consent to Photograph

In connection with the services, which I am receiving, from **Beth Moffett, RNFA** , I, the undersigned does hereby authorize the above named practitioner to photograph before and after pictures of my treatment/procedure.

Under the following conditions:

1. The photographs may be taken only with the consent of my practitioner and under such conditions and at such times as may be approved by her.
2. The photographs shall be taken by my practitioner or by her assignee.
3. These photographs shall only be used for medical record, unless in the judgement of my practitioner, research, education, promotional, and/or science will benefit from their use.
4. In the event the photos are used for research, education, promotion, and/or science my identity will be omitted.

Patient Signature: _____ Date_____

Statement of Understanding & Notice of Privacy

I agree that the determination of professional services to be rendered by Beth Moffett, RNFA and the fees to compensate her for these services are matters concerning my practitioner and me. I understand that I have a primary duty and obligation to pay Beth Moffett, RNFA for her services when rendered.

Neither Beth Moffett, RNFA nor I will permit any third party to determine what services I need or what fees she should receive in return for these services. Any agreement that either of us may have with any third party shall not affect our relationship and the decisions relating to care and fees. Neither Beth Moffett, RNFA nor I as the Patient are in any way bound by any contract the other may have with any third party.

We are required by law to maintain the privacy of, and provide individuals with this notice of our legal duties and privacy practices with respect to protected health information.

Signature below is only an acknowledgement that you have read this Notice of our Privacy Practices and all pages of the patient registration form.

Patient Signature_____ Date_____