River Region Facial Plastics

New Patient information Sheet Date:_____

Name:_____ Age: _____

Birth Date: _____ Height: _____ Weight: _____

Social Security #_____

How did you find us?

_____

Martial Status (circle one): Married - Single - Divorced - Widowed

Sex (circle one): M F Ethnicity:_____

Work Phone:_____

Home Phone:_____

Cell Phone:_____

Please circle best contact number above

Address:_____
_____ City:_____ State:_____ Zip Code:_____

Email address:_____

May we put you on our email list for specials, promotions, & coupons? YES or NO
(*We will never sell or give out your contact information)*

Are you a member of Allergan Rewards Program Brilliant Distinctions?

Emergency contact:_____

Phone #:_____ Relationship to you:_____

Please list ALLERGIES to medicines, latex or supplements: (List medication & reaction)

_____
_____

Please list all MEDICATIONS & SUPPLEMENTS:

_____
_____
_____
_____
_____
_____

Please list all your MEDICAL PROBLEMS (Treated or untreated):

_____
_____
_____
_____
_____
_____

Please list all surgeries you have had, including cosmetic surgeries (LIST SURGERY AND APPROXIMATE YEAR:)

_____
_____

_____
_____
_____
_____

SOCIAL HISTORY: **Do you use tobacco?** ☐ Never ☐Cigarettes _____ packs/day ☐Cigars ☐Pipe ☐Dip

☐ I quit smoking/use of tobacco as of_____

How many years have/did you use tobacco?
_____

Do you normally have more than 2 drinks of alcohol per day? ☐ Yes ☐ No

What is your occupation? _____

YOUR REGULAR/FAMILY PHYSICIAN & DATE OF LAST EXAM:

LIST ANY OTHER PHYSICIANS YOU HAVE SEEN IN THE LAST SIX (6) MONTHS:

_____
_____

Do any medical problems run in your family?

_____

Are you frequently sick or ill? □ Yes □No

Do you drink more than 6 cups of coffee per day? □ Yes □No

Have you ever been under the care of a psychologist or psychiatrist? □ Yes □No

Have you been diagnosed with depression or other psychiatric problem? □ Yes □No

If yes, please explain.

_____
_____

Is there anything else about your health history we should know? If so please list:

Do you understand that medical and surgical treatments cannot promise or guarantee a good outcome?

□ Yes □ No

Do you understand that all risks and complications cannot be prevented when a surgical procedure is performed? □ Yes □ No

Please list your current skin care regimen:

Have you ever had (check all that apply):

□ Botox/Dysport/Xeomin

□ Dermal fillers (Juvederm, Restylane, Voluma, Radiesse)

Have you ever had (check all that apply continued)

□ Sculptra

□ Eye rejuvenation

THIS IS A CONFIDENTIAL REPORT OF YOUR MEDICAL HISTORY. INFORMATION CONTAINED HEREIN

WILL NOT BE RELEASED TO ANY PERSONS EXCEPT WHEN YOU HAVE AUTHORIZED US TO DO SO.

REGARDLESS OF INSURANCE COVERAGE, I UNDERSTAND THAT I AM PERSONALLY RESPONSIBLE FOR THE PAYMENT OF ALL CHARGES INCURRED FOR SERVICES RENDERED TO ME OR THE PATIENT NAMED ABOVE.

Signature: _____

Date: _____

Thank you for filling out these forms!