PATIENT INFORMATION FORM

Patient Name: _____ Nickname: _____

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

Home Phone: _____ Cell Phone: _____ Work: _____

DOB & Age: _____ Race: _____ Ethnicity: ☐ Hispanic ☐ Non-Hispanic

Gender: _____ SSN: _____ Email Address: _____

Employer Name: _____ Address: _____

Occupation: _____

Primary Care Physician & Number: _____

How did you hear about our clinic?

☐ Online Search ☐ Patient Referral: _____ ☐ Other: _____

☐ Facebook ☐ Friend: _____

☐ Instagram ☐ Dr. Referral: _____

Emergency Contact _____ Relationship: ☐ Spouse ☐ Parent/Guardian ☐ Other:

Cell Phone: _____

PRIMARY INSURANCE

For non-cosmetic patients: please provide copy of your insurance card to our staff upon check in.

ASSIGNMENT AND RELEASE

I, _____ , have insurance coverage and assign all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions.

_____ _____

Signature of Insured / Guardian Date

SECTION 1: SURGERY AND ANESTHESIA HISTORY

1. Have you ever had surgery? ☐ No ☐ Yes, please list operations and dates:

_____

_____

2. Do you or a blood relative ever had any anesthesia complications? ☐ No ☐ Yes, please describe:

SECTION II: MEDICAL HISTORY & PRESENT ILLNESS

1. Height: Weight: Women: Are you pregnant? ☐ No ☐ Yes, how long?

2. Have you been diagnosed with any of the following illnesses? Cirlce all that apply.
asthma / sleep apnea / emphysema / bronchitis / hypertension / heart disease / heart attack / hepatitis or liver disease / diabetes / seizures or epilepsy / stroke / bleeding disorder / HIV or AIDS / autoimmune disease / scarring or keloid / mood disorder / anxiety or panic disorder / psychiatric disorder
Others not listed: _____

SECTION III: SOCIAL HISTORY

Do you smoke? ☐ No ☐ Yes Do you drink alcohol? ☐ No ☐ Yes Recreation Drugs:

SECTION IV: FAMILY HISTORY

Please list any significant family history of illness or cause of death in close relatives:

SECTION V: MEDICATIONS

Are you taking any medications, vitamins or herbal supplements? ☐ No ☐ Yes, please list:

SECTION VI: DRUG ALLERGY

Are you allergic to any medications or local anesthesia? ☐ No ☐ Yes, please list:

I have read this questionnaire and disclosed my surgical and medical history to the best of my knowledge.

Patient Signature: _____ Date: _____

COMMUNICATION CONSENT

Patient Name:

Please mark the ways that you consent to us communicating with you:

Method	Ok to Leave Voicemail	Ok to Leave Message with Another Person	Preferred Contact Method(s)	Best Time to Call*
☐ Call Work Phone	☐ Yes ☐ No	☐ Yes ☐ No	☐	
☐ Call Cell Phone	☐ Yes ☐ No	☐ Yes ☐ No	☐	
☐ Call Home Phone	☐ Yes ☐ No	☐ Yes ☐ No	☐	
☐ Send Email	-	-	☐	-
☐ Email Appointment Reminders				
☐ Email Medical Information				
☐ Email Office Specials				
☐ Send Regular Mail	-	-	☐	-
Mail to which Address: ☐ Home ☐ Other (please list):				
☐ Send Text Message – if so, list cell carrier:			☐	-
☐ Text Appointment Reminders				
☐ Text Office Specials				

Best Time to Call Examples: morning, afternoon, daytime, evening, emergency only, do not call, or do not leave a message

Signature: _____ Date: _____

RADIANCE
AESTHETIC SURGERY & WELLNESS SPA