Patient Registration & Health History Forms

Physician Name: ______________________________________ **Appointment Date:** __________________

Thank you for choosing to visit with us at DMG Aesthetics. As part of our efforts to provide excellent care for you, we need your help in understanding your complete medical history. The questions on this form will assist us in giving you the best care possible. If you have any difficulties understanding this document and require assistance, please ask for help.

(Please write legibly)

Last name:	**First name:**	**Middle initial:**
Last 4 digits of your Social Security number: XXX – XX –		
Sex:	**Date of Birth:**	(Age: ________ years old)

Martial Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed		
Address:		
City:	**State:**	**Zip Code:**
e-mail Address: **Would you like to receive promotions, notifications, & monthly newsletters from us? Yes**☐ **No**☐		
Home Phone Number:	**Mobile Phone Number:**	
Preferred number to contact you at: ☐ Home ☐ Mobile ☐ Other:		
Who may we thank for referring you to DMG Aesthetics?		
What is the reason for your visit; What would you like to discuss with the physician during your reservation time?		

Emergency Contact First Name:	**Last Name:**	
Home Phone Number:	**Work/Cell Phone Number:**	**Relationship:**

Primary Care Physician First and Last Name:	**Phone Number and City:**

Authorization for Treatment

I agree to any examination, treatment, and procedures that may be performed during aesthetic office visits, including emergency treatment considered necessary by the physician and his/her providers.

Patient Signature: X____ **Date**: ____________________

PAST MEDICAL HISTORY

Please list all current and previous medical illnesses and problems: If none, please check here ☐

1		5	
2		6	
3		7	
4		8	

If you choose not to disclose any medical history it could affect your surgical outcome.

Patient Initials: _______________

MEDICATIONS

Please list all current medications If none, please check here ☐
(prescription, over the counter, vitamins and herbal products)

	NAME	DOSAGE	TIMES PER DAY	REASON FOR TAKING MEDICATION
1				
2				
3				
4				
5				
6				
7				
8				

If you choose to not disclose any or incorrect medication information it could affect your surgical outcome.

Patient Initials: _____________

PAST SURGICAL HISTORY

Please list all past surgeries If none, please check here ☐

	OPERATION	YEAR	PERFORMING SURGEON
1			
2			
3			
4			
5			

If you choose not to disclose any surgical history it could affect your surgical outcome.

Patient Initials: ______________

FAMILY HISTORY

Have you or any family member ever had problems or complications with any local or general anesthesia? Please explain:

Have you or any family members ever had problems or complications with excessive bleeding or a known blood clotting disorder? Please explain:

Are you pregnant, planning for impending pregnancy or is there any possibility that you may currently be pregnant?

Patient Initials: __________

Allergies

Please list any medication allergies: ____ If none, please check here ☐
Please list any food or environmental allergies: ______________________________________ If none, please check here ☐
Please check if you are allergic to any of the following: ☐Latex ☐Tape ☐Shellfish ☐Iodine contrast/dye

Social History

Marital status: ☐Single ☐Married ☐Divorced ☐Widowed
Occupation: ____ Employer: ____________________________________
Do you currently smoke? ☐Yes ☐No If yes, how many? _______packs/day. How long? ________years.
Have you ever smoked? ☐Yes ☐No How many? ______packs/day. How long? ______years. When did you quit? ______
How many alcoholic drinks do you drink per week? ___________drinks/week.
Do you currently use or have you ever used cocaine, heroin, intravenous or other illegal drugs? ☐Yes ☐No

Family History

Please list any medical diseases in your immediate relatives, including cancer:
Mother/Father: ____
Brothers/Sisters: ____
Children: ____

Overview of Your Current Health

Please circle if you have experienced any of the symptoms or problems listed below:

- Fevers or chills
- Weight loss
- Sweats or excessive sweating (hyperhydrosis)
- Fatigue
- Visual problems
- Breathing or lung problems (asthma, COPD)
- Chest pain (heart attack)
- Heart problems (pacemaker, murmur)
- Stroke or headache problems
- Blood pressure or circulation problems
- Blood or lymph node diseases
- Excessive or abnormal bleeding
- Stomach or digestive problems (ulcer, heartburn)
- Sleep apnea or snoring problems
- Bone, muscle or joint problems
- Depression, anxiety or mental illness
- Skin conditions, growths or cancers
- Allergy or immune problems
- Kidney, bladder or urination problems
- Sexual, gynecologic, or testicular problems
- Seizure, nerve or brain disorders
- Thyroid, endocrine or hormone disorders
- Tuberculosis or infectious disease
- HIV or AIDS
- Hepatitis A, B or C
- Excessive scarring
- Recent dental work
- MRSA (history or active)

Any other symptoms or problems not listed? ____
____

Please explain if you have answered yes to any of the above problems or symptoms: ______________________
____

Height: ________’ ___________” Weight: _________________ lbs (Office Use BMI: _______________)

I understand the above questions and I have answered each question to the best of my knowledge. I understand that incomplete or inaccurate information may compromise my medical care. I agree to provide updated information to the physicians of DMG Aesthetics if and when my medical information has changed, or as requested of me from the physician. As a patient, I will follow DMG Aesthetics policies and provider instructions. I will review all documents and have all my questions answered prior to completing any service or treatment. I wish to proceed with this consultation for the procedure in which I am interested in as my choice.

____ ______________________

Patient/Guardian Signature **Date**

____ ______________________

Physician Signature **Date**

DuPage Medical Group
WE CARE FOR YOU

CONSENT FOR VERBAL RELEASE OF INFORMATION

1. Please list your preferred numbers:

   Home: ______________________ **Cell:** ________________________ **Work:** __________________________

2. Which phone number is best to use during the day (8am – 4pm)? ☐ **Home** ☐ **Cell** ☐ **Work**
3. Which phone number is best to use in the evening (4pm – 7pm)? ☐ **Home** ☐ **Cell** ☐ **Work**
4. Check box if we may leave detailed messages, including appointment reminders, on your voicemail*.

   ☐ **Home** ☐ **Cell** ☐ **Work**

5. Check box if we may leave detailed lab/test results on your voicemail*.

   ☐ **Home** ☐ **Cell** ☐ **Work.**

   * Answering machines and voice mail must have an identifying message to confirm these are your numbers for example; "You have reached John Doe"

6. Please list your preferred pharmacy:

   Pharmacy Name: ____

   Pharmacy Phone Number: ____

7. Please list any persons with whom we MAY share details about your health care. Indicate below whether this may include **sensitive health information (SHI**) such as mental health, developmental disabilities, AIDS/HIV or other STD treatment and/or diagnosis, Drug/Alcohol abuse diagnosis, treatment and/or referral and Genetic Testing.

NAME	RELATIONSHIP	RELEASE SHI?
		Yes No
		Yes No
		Yes No
		Yes No

I understand that this consent is valid until it is revoked by me. I understand that I may revoke this consent at any time by giving written notice of my desire to do so, to the physician. I also understand that I will not be able to revoke this consent in cases where the physician has already relied on it to use or disclose my health information. Written revocation of consent must be sent to the physician's office.

Patient Signature: ____ Date: _________________________

Printed name: ____ Date: __________________________

Receipt of Notice of Privacy Practices Form (HIPAA)

I, ______________________________________/______________ herby acknowledge receipt
First Name, Last Name /Patient Date of Birth

of DuPage Medical Group's Notice of Privacy Practices. The Notice of Privacy Practice provides detailed information about how this medical group may use and disclose my confidential information.

I understand that DuPage Medical Group and DMG Aesthetics reserve the right to change its privacy practices that are described in the notice. I also understand that a copy of any revised notice will be provided to me or made available to me.

Patient Signature: ____ Date: _________________

Guardian Signature:_______________________________________ Date: __________________

Relationship to Patient: _______________________________________

Patient Name: ____

PATIENT PHOTOGRAPHIC AUTHORIZATION AND RELEASE

I consent to the taking of photographs or videotapes of me or parts of my body, or for the person for whom I am a legal guardian, by DMG Aesthetics and/or their designee in connection with the procedure for which I am being consulted. Unless I have consented to the additional uses below, I understand that my medical photography will only be used for treatment, payment, and healthcare administration. By consenting to these medical photographs I understand that I will not receive payment for any part of their use.

I also give my permission to use my medical photography for the following uses by circling " yes " or " no " on each line below:

Yes / No I consent of these photographs to be used in any print, visual, or electronic media including, but not limited to, medical journals, textbooks, scientific presentations, teaching courses, internet websites, brochures, posters, and practice portfolios to be shown to other patients for the purpose of informing the medical profession or general public about plastic surgery methods. I understand that I will not be identified by name in any medium, though in some circumstances the photographs may portray features that shall make my identity recognizable.

Yes / No I consent for the photographs to be used for educational purposes only. I understand that I will not be identified by name in any medium, though in some circumstances the photographs may portray features that shall make my identity recognizable.

- I understand that the information disclosed, or some portion thereof, may be protected by state law and/or the federal Health Insurance Portability and Accountability Act of 1996 ("HIPAA")
- I understand that I may refuse to sign this authorization and such refusal to consent will prevent the disclosure of such information and will have no effect on the medical treatment I receive from the providers of DMG Aesthetics.
- I understand that I have the right to revoke this authorization in writing at any time, but if I do so it will have no effect on any actions taken prior to my revocation.
- I release and discharge the photographs to DMG Aesthetics and all parties acting under the providers license and authority from all rights that I may have in the photographs and from any claim that I may have relating to such use in publication.

____ ____________________
Patient Signature Date

____
Witness / Physician Signature

I have read the above *Photographic Authorization and Release*. I am the parent, guardian, or conservator of the patient listed below who is a minor. I am authorized to sign this consent on his/her behalf.

____ ____________________
Parent / Guardian Signature Date

____
Witness / Physician Signature