AEGEAN

MEDICAL

Patient Information

Appt. Date: _____

First Name:		**Last Name:**	
DOB:		**Sex:**	**Age:**
Address:		**Email:**	
City:		**State:**	**Zip Code:**
Cell Phone	Text? ☐ Yes ☐ No	**Home Phone:**	
Pharmacy:		**Pharmacy Address:**	
Primary Doctor:		**Phone Number:**	

Emergency Contact Information

First Name:	**Last Name:**
Relation:	**Phone Number:**

Referral Information

How did you find out about our office?

Cancellation Policy

I understand and agree that it is my responsibility to notify Aegean Medical **24 hours prior** to the scheduled appointment if I am unable to keep the scheduled appointment. In the event that I miss an appointment and/or fail to notify the office at least 24 hours in advance, I understand and agree that I will be billed the contracted rate of **$25 for follow up visits,** or **5% of my deposit for procedure appointments**

Signature: _____ Date: _____

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Medical History Pt. Name: DOB:

Do you currently have or have you had any of the following?

Yes	No		Yes	No	
		Cancer, type:			Autoimmune Disease
		Heart Disease or Heart Attack			Eczema, Psoriasis or other Skin Issues
		High Blood Pressure			Diabetes
		Pacemaker or Internal Defibrillator			Thyroid Disease
		Metal or Surgical Implants**			Kidney Disease
		Bleeding Issues			Uterine Prolapse, Cystocele, Rectocele
		Clotting Issues			Cosmetic Procedures in Past 3 Months
		Abnormal Wound Healing			Fillers or Injectables in Past 3 Months
		Asthma, COPD or other Lung Issues			Use of Accutane in Past 6 Months
		Arthritis			Other:
		Herpes (cold sores, genital)			

** Metal or Surgical Implants, if yes please explain:

Female Patients: Are you pregnant? Nursing? Trying to become pregnant? ☐ Yes ☐ No (if yes, please circle which applies)

Date of your last PAP? _____ was it normal? ☐ Yes ☐ No, explain:

Are you allergic to (circle): **Latex** **Iodine** **Adhesives**

Please list any medications/products you are **ALLERGIC** to: _____

List all medications **you are currently taking**:

1.) _____ 3.) _____ 5.)_____
2.) _____ 4.) _____ 6.)_____

Please list any previous surgeries: _____

_____

Tobacco Use: ☐ Yes ☐ No **Alcohol Use: ☐ Yes ☐ No ☐ Occasionally**

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Pt. Name: _____ DOB: _____

Areas of Concern: (Please check all that apply)

☐ Abdomen	Face
☐ Flanks	☐ Neck / Jawline
☐ Back	☐ Lips
☐ Breast / Chest area	☐ Eye area
☐ Thighs / Hips	☐ Wrinkles, Acne, Scars, Loose Skin, Other
☐ Legs	Vaginal
☐ Arms	☐ Stress Incontinence
☐ Buttocks	☐ Dryness
☐Other:	☐ Elasticity

Services that interest you: (Please check all that apply)

☐ Liposuction	☐ Botox / Fillers
☐ Breast Enhancement	☐ Microneedling (RF or Dermapen)
☐ Buttocks Enhancement	☐ PRP for hair loss
☐ Fat Transfer	☐ Non- Surgical Facelift.
☐ Skin Tightening: ☐ Body ☐ Neck / Jaw	☐ Vaginal Rejuvenation
☐ Stem Cell Treatment	☐ Scarless Breast Reduction
☐ Breast Lift	☐ Other

List all Previous Cosmetic Treatments: (Liposuction, Botox, Laser Skin Treatments…)

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Notice of Privacy Practices Acknowledgment

I understand that under the Health Insurance Portability and Accountability Act (HIPAA), I have certain rights to privacy regarding my protected health information. I acknowledge that I have received or have been given the opportunity to receive a copy of your Notice of Privacy Practices. I also understand that this practice has the right to change its Notice of Privacy Practices and that I may contact the practice at any time to obtain a current copy of the Notice of Privacy Practices.

_____ **DOB:** _____

Patient Name or Legal Guardian

_____ **Date:**_____

Signature

I authorize Aegean Medical to communicate appointment, treatment and financial information to me in the following ways:

- Leave message via voicemail or person on my home phone
- Leave message or speak to me on my mobile phone
- Via text to my mobile phone or via email to _____

I give my permission for Aegean Medical to share information about me with the person(s) listed below. This can include diagnosis, test results, treatment, prescription, appointment and financial information. This authorization will remain in effect until I notify Aegean Medical in writing changing or deleting this authorization. By signing this authorization, I authorize Aegean Medical to receive, use and/or disclose certain protected health information (PHI) about me to the following person(s):

_____.

Office Use Only----------

We have made this following attempt to obtain the patient's signature acknowledge receipt of the Notice of Privacy Practices. Date: _____

Attempt: _____ Staff Name: _____