

Patient Registration

Patient: _____ Today's Date: _____
Last Name First Name Middle Initial Preference

Address: _____ [] Home: _____

City: _____ State: _____ Zip: _____ [] Work: _____

Email: _____ [] Mobile: _____

Birth date: _____ Age: _____ Sex: [] male [] female

Would you like to hear about new products and promotions? [] yes [] no

May we contact you to remind you about upcoming appointments? [] yes [] no

Patient's Employer: _____ Patient's Occupation: _____

Marital Status: [] single [] married [] widowed [] separated [] divorced

Insurance Information

Primary Insurance: _____ Secondary Insurance: _____

ID # _____ ID# _____

Group # _____ Group # _____

***WE ARE IN NETWORK WITH THE FOLLOWING INSURANCE PLANS: BLUE CROSS BLUE SHIELD, PREMERA, MEDICARE, LIFEWISE, HMA & REGENCE DEPENDING ON YOUR INSURANCE PLAN AND POLICY YOU MAY HAVE FULL, LIMITED OR NO COVERAGE WITH OUT OF NETWORK PROVIDERS. (initial)**

Emergency Information and Release

In case of an emergency, local friend or relative to be notified (not living at same address if possible):

Name: _____ Relationship to Patient: _____

Home Phone: () _____ Work Phone: () _____

Assignment and Release: I hereby authorize my insurance and government benefits be paid directly to the physician. I am financially responsible for any balance due. I also authorize the doctor or insurance company to release any information required for this claim.

Signature: _____

How Did You Hear About Us?

[] A friend or family member (name) _____ may we contact him/her [] yes [] no

[] Seattle Magazine Top Doctors / Best Cosmetic Surgeon Readers' Choice Award

[] Best of 425 Magazine - Best Cosmetic Surgeon and Best Place for Skincare Award

[] Internet Search: [] Google [] Bing [] realself.com [] Yelp.com [] citysearch.com [] other _____

[] Facebook

[] An article or television / radio appearance in _____

[] Newsletter or mailer

[] Auction or charitable event (please specify) _____

[] My physician (full name) _____

[] Other (please specify) _____

If you have any specific **interests**, please check all that may apply:

Facial Cosmetic Surgery

- Rhinoplasty
- Face & Neck Lift
- Eye Lid Lift
- Brow & Forehead Lift
- Cheek & Midface Lift
- Laser Resurfacing
- Fractional Laser Resurfacing
- Chin Augmentation
- Cheek Augmentation
- Neck Liposuction
- Lip Augmentation
- Lip Lift
- Buccal Fat Removal
- Otoplasty
- Fat Injections
- Feather Lift

Body Cosmetic Surgery

- Breast Augmentation
- Breast Lift
- Breast Reduction
- Buttock Lift
- Liposuction
- Abdominoplasty
- Arm Lift
- Full Body Lift
- Body Contouring
- Fat Injection to Breast
- Fat Injection to Body
- Hand Rejuvenation

Reconstructive Surgery

- Septoplasty
- Skin cancer
- Facial trauma
- Ptosis surgery
- Eyelid reconstruction
- Tearing problems
- Hand Surgery

Injectables

- Botox & Dysport
- Restylane
- Juvederm
- Radiesse
- Perlane
- Sculptra
- ArteFill
- Fat Injections
- Sclerotherapy

Laser Treatments

- Thermage for Face
- Thermage for Body
- Thermage for Cellulite
- CoolSculpting Cryolipolysis
- Non-invasive fat removal
- Fotofacial
- Intensive Fotofacial
- Facial Vein Removal
- Leg Vein Removal
- Freckles & Brown Spots
- Laser Hair Removal
- Polaris

Dermatology

- Skin cancer screening
- Mole checks
- Biopsies
- Skin aging
- Acne
- Acne scars
- Rosacea
- Biopsy-proven skin cancer
- Suspected skin cancer
- Mole removal
- Cysts
- Lipoma
- Skin lacerations (cuts) and scars resulting from prior injury
- Rashes
- Eczema
- Warts
- Fungal infections
- Bacterial infections
- Hair loss/alopecia
- Pigmentation issues

Skin Care & Products

- Microdermabrasion
- Skin Care Analysis
- Chemical Peels
- ToneAbrasion
- Obagi products
- Latisse for eyelashes
- Skin Medica products
- SPF
- ScarFade

Please answer the following questions on a scale of 1 to 5 by **circling** the appropriate number:

When looking at my face in the mirror, I believe I look younger, the same as, or older than my true age.

Younger Than		True Age		Older Than
1	2	3	4	5

Each day, I look at myself in the mirror:

Once or twice per day		Every now and then to freshen up		More than 10 times per day
1	2	3	4	5

I am looking for a procedure that can give me a:

Small improvement with minimal down-time		Moderate improvement with some down-time		Significant improvement with longer down-time
1	2	3	4	5

MEDICAL HISTORY FORM

Name: _____

Date of Birth: _____

MEDICATIONS (including over the counter):

- 1. _____
- 2. _____
- 3. _____
- 4. _____
- 5. _____

Please attach a sheet if more space needed

DRUG ALLERGIES (indicate what happens)

- 1. _____
- 2. _____
- 3. _____
- 4. _____
- 5. _____

Please attach a sheet if more space needed

MEDICAL ILLNESSES

- 1. _____
- 2. _____
- 3. _____
- 4. _____
- 5. _____

Please attach a sheet if more space needed

PAST SURGICAL PROCEDURES

- 1. _____
- 2. _____
- 3. _____
- 4. _____
- 5. _____

Please attach a sheet if more space needed

FAMILY HISTORY (Please indicate **F**ather, **M**other, **G**randparent, **S**ibling)

_____ Allergies/Asthma
 _____ Anesthesia reaction
 _____ Bleeding tendency
 _____ Cancer

_____ Diabetes
 _____ Heart disease
 _____ High blood pressure
 _____ Melanoma

_____ Mental illness
 _____ Seizures/Epilepsy
 _____ Skin cancer
 _____ Stroke

SOCIAL HISTORY

Occupation: _____ Hobbies: _____

Marital status (please circle): Single Married/Partner Separated Divorced Widowed

Do you smoke? Y N
 Have you ever smoked? Y N
 When did you quit? _____
 How many years did you smoke? _____
 How many packs/day average? _____

Do you drink alcoholic beverages? Y N
 Average number of drinks/day: 1 2 3 4+
 Are you at high risk for HIV/AIDS? Y N
 Have you been HIV tested? Y N
 HIV test results: Positive Negative

Are you pregnant or nursing? Y N
 Were you hospitalized in the last 6 months? Y N
 Are you under the care of a doctor? Y N
 Have you ever been on Accutane for Acne? Y N
 Have you ever had plastic surgery? Y N

SYSTEMIC REVIEW: Please circle **Yes** or **No** if you have or you ever have had any of the following

SKIN

Abnormal pigmentation Y N
 Acne Y N
 Burns very easy Y N
 Hives, Eczema, Rash Y N
 Melasma (pregnancy mask) Y N
 Skin cancer/Melanoma Y N
 Tans very easy Y N
 Thick, raised, itchy scars Y N
 Cold sores Y N

HEAD/EYE/EAR/NOSE/THROAT

Allergy/Hay fever/Itchy eyes & nose Y N
 Broken nose Y N
 Dizziness Y N
 Double vision/Blurry vision Y N
 Dry eyes requiring treatment Y N
 Facial weakness/Paralysis Y N
 Glaucoma Y N
 Impaired hearing Y N
 Nosebleeds Y N
 Sinus infections Y N

NECK

Radiation treatment Y N
 Spine surgery Y N
 Surgical removal of tumor Y N

RESPIRATORY

Asthma Y N
 Chronic cough Y N
 Difficulty breathing Y N
 Pneumonia Y N
 Pulmonary embolism Y N
 Sleep apnea Y N
 Tuberculosis Y N

CARDIOVASCULAR

Angina/Chest pain Y N
 Angioplasty Y N
 Bypass surgery Y N
 Congestive heart failure Y N
 Heart attack Y N
 Heart murmur Y N
 Heart valve disease/artificial valve Y N
 High blood pressure Y N
 Irregular heart rhythm Y N
 Pacemaker or Defibrillator Y N
 Rheumatic fever Y N
 Shortness of breath with exercise Y N
 Stent placed in heart Y N
 Swelling of ankles Y N

GASTROINTESTINAL

Anorexia Y N
 Difficulty swallowing Y N
 Frequent Constipation Y N
 Frequent Diarrhea Y N
 Hepatitis A, B, or C Y N
 Liver malfunction Y N
 Peptic ulcer Y N
 Reflux disease Y N
 Unexplained weight loss Y N
 Vomiting blood Y N

GENITOURINARY

Blood in urine Y N
 Frequent urination Y N
 Kidney malfunction Y N
 Kidney stones Y N
 Painful urination Y N

MUSCULOSKELETAL

Arthritis Y N
 Artificial joints Y N
 Blood clots in legs Y N
 Broken bones Y N
 Poor circulation to legs Y N
 Ulcers on feet Y N
 Varicose veins Y N

HEMATOLOGIC

Anemia Y N
 Easy bruising Y N
 Excessive bleeding Y N
 Hemophilia Y N
 Phlebitis Y N

ENDOCRINE

Diabetes Y N
 Glucose intolerance Y N
 Thyroid disease Y N

NEUROPSYCHIATRIC

Anxiety Y N
 Bipolar disorder Y N
 Body image problems Y N
 Convulsions Y N
 Depression Y N
 Obsessive-Compulsive disorder Y N
 Panic disorder Y N
 Stroke or Paralysis Y N
 Have you ever had psychiatric care? Y N
 Are you under current psychiatric care? Y N

Please list any other medical conditions not listed above: _____