A W A K E N A E S T H E T I C S

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AWAKENAESTHETICS.COM

NEW PATIENT INFORMATION

PERSONAL INFORMATION

FULL NAME		DATE OF BIRTH	
GENDER		SOCIAL SECURITY #	
HEIGHT		WEIGHT	
ADDRESS			
CELL PHONE			
EMAIL			
EMERGENCY CONTACT:		RELATIONSHIP:	
CELL PHONE:			
PRIMARY CARE DOCTOR			
REFERRED BY			

IF UNDER 18 YEARS OF AGE

NAME OF PARENT/GUARDIAN	
CONTACT	

CURRENT OR PAST MAJOR ILLNESSES	**Date**

PRIOR COSMETIC PROCEDURES (BOTOX, FILLER, LASER, SURGERY, ETC)	**Date**

OTHER PRIOR SURGERIES OR PROCEDURES **Date**

ALLERGIES

MEDICATIONS

Do you *currently* have any problems in the following areas? If YES, please describe:

	YES	NO	Please specify
GENERAL (Fever, Weight loss, etc.)			
SKIN (Sensitivities, poor healing, cancer, diseases, etc.)			
EAR, NOSE, THROAT (Sinus, cough, etc.)			
CARDIOVASCULAR (Heart, vessels, etc.)			
RESPIRATORY (Asthma, Emphysema, Sleep apnea,			
GASTROINTESTINAL (Reflux, Ulcer, etc.)			
GENITAL, KIDNEY, BLADDER (Incontinence, etc.)			
MUSCLES, BONES, JOINTS (Arthritis, etc.)			
NEUROLOGICAL (Multiple sclerosis, Migraines, etc.)			
PSYCHIATRIC (Anxiety, Depression, Insomnia, etc.)			
ENDOCRINE (Diabetes, Thyroid, etc.)			
BLOOD, LYMPH (Anemia, Bleeding tendency, etc.)			
ALLERGIC, IMMUNOLOGIC (Hay fever, Sjogrens,			

FAMILY & SOCIAL HISTORY:

DISEASE	YES	NO	Relationship to Patient
Abnormal bleeding			
Adverse anesthetic reaction			
Other:			

Current occupation:	
Education:	
Marital Status:	
Living arrangement (Live alone, assisted living, etc.):	
Nicotine Use (Current and past):	
Alcohol Use (Drink per week):	
Recreation Drug Use:	

CONSENT FOR TREATMENT:
The undersigned authorizes Awaken Aesthetics to provide treatment of procedures, which the provider considers necessary and proper in the treatment of the above-named patients.

NO SHOW POLICY:
1. Patient who does not call to cancel or reschedule 24 – 48 hours prior to their schedule appointment may incur a $100 NO SHOW FEE.
2. Patients who have paid in full for surgery and cancel may be subject to 50% forfeiture.

LEGALITY:
1. Any legal dispute that arises with Awaken Aesthetics, the patient will be responsible for legal fees incurred by Awaken Aesthetics.
2. Awaken Aesthetics reserves the right to decline further services to the patient for non – payment.

ACKNOWLEDGEMENT OF RECEIPT NOTICE OF PRIVACY PRACTICES:
By my signature below, I acknowledge that I have been made aware of and have been provided information regarding the Health Insurance Portability and Accountability Act (HIPAA) and the Awaken Aesthetics Notice of Privacy Practices.
Our office is fully committed to compliance with HIPAA guidelines by:
1. Providing appropriate security for our patient records.
2. Protecting the privacy of our patient's medical information.
3. Providing our patients with proper access to their medical records.
4. Appropriately maintaining our patient information and billing processes in compliance with national standards.

If you would like a detailed copy of Notice of Privacy Practices, please ask the receptionist.

PAYMENT OPTIONS:
Thank you for choosing Awaken Aesthetics. Our primary mission is to deliver the best and most comprehensive medical and cosmetic care available. An important part of the mission is making the cost of optimal care as easy and manageable for our patients as possible by offering several payment options. Should you decide to proceed with treatment in the future the following are your payment options.
You can choose from:
- Visa, Mastercard, Discover, American Express, Debit or ATM
- Cash
- Check (established patients only)
- Payment plans from Care Credit

Awaken Aesthetics charges $25 for returned checks.
If you have any questions, please do not hesitate to ask. We are here to help you get the cosmetic treatment you want and need. By signing below, I acknowledge that I have read and understand the payment options offered at our office.

Marketing Communications
We don't want you to miss out on special offers, vouchers or other promotions that we think would interest you. Remember, you can opt out at any time.

I want to receive communications from Awaken Aesthetics by: ☐Email ☐Text ☐Phone ☐Social media

I do not want to receive commmunications from Awaken Aesthetics: ☐Opt out

Patient, Parent or Guardian Signature: _____ DATE: _____

Patient Name (Please Print): _____