BLUE MEDSPA

Registration and History Form

Personal Information

Name: _____ Date of Birth ___/___/___ Age____ Sex_____
S.S.#: _____-_____-_____ Height_____ Weight _____ Number of Children_____
Home Address _____
City _____ State _____ Zip_____
Where may we leave messages? ( ) Home _____ ( ) Cell _____
( ) Work _____ ( ) Email_____
( ) Spouse _____ ( ) Other _____
Employment _____
Marital Status ( ) Married ( ) Single ( ) Divorced ( ) Separated ( ) Widowed
Name of Spouse _____ Spouse's Employer _____
In case of emergency, contact _____ Phone _____
Relationship _____
Who is responsible for charges? _____

Medical History

List all allergies: Medicine or contact (i.e. Latex) _____
_____
_____
List all medications: Prescription and non-prescription _____
_____
_____
Are you a smoker? : ( ) Yes ( ) No – If so, how much_____
Do you drink alcohol? : ( ) Yes ( ) No – If so, how much? _____
Anesthesia problems or concerns: _____
_____
Please tell us about ANY serious illness you have had in the past. For example: heart disease, blood pressure problems, pulmonary disease, diabetes, thyroid trouble, stomach ulcers, sleep apnea, etc. _____
_____
_____
Please list any **operations** you have had (including cosmetic surgery). Give approximate dates: _____
_____
_____

Please use the space below to discuss your reason for consultation:

_____
_____
_____
_____

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Primary Insurance

Primary Insurance: _____
Policy Holder Name: _____
DOB of Policy Holder: _____
SSN# of Policy Holder: _____

***If filing insurance, your specialist copay is due at time of visit.**

Secondary Insurance

Primary Insurance: _____
Policy Holder Name: _____
DOB of Policy Holder: _____
SSN# of Policy Holder:_____

Why did you select our center? Please indicate all that apply:

( ) Patient Referral. May we ask who? _____ May we acknowledge referral ( ) yes ( ) no
( ) Doctor Referral. May we ask who?_____ May we acknowledge referral ( ) yes ( )no
( ) General Reputation or recommendation ( ) Speaking Engagement – Where _____
( )Other_____

I HAVE READ THIS FROM ENTIRELY AND HAVE COMPLETED IT FULLY AND ACCURATELY TO THE BEST OF MY KNOWLEDGE.
Patient Signature _____
Date this form was completed _____