IREVIVE HEALTH & WELLNESS, LLC

AESTHETIC REGISTRATION

Name:		**Date:**
Address:		**Sex :** MALE / FEMALE (circle one)
City / State:	**ZIP:**	**Date of Birth:**
E-MAIL:		**Age:**
Primary Phone:		**Height:**

Are you registered with Brilliant distinctions? Yes / NO Member #

What aesthetic concerns do you have?

	Wrinkles
	Rosacea/Redness, Hyperpigmentation/Brown Spots, Melasma, Acne, Scarring, Stretch Marks
	Skin care advice/Products
	Botox
	Cosmetic Fillers
	Chemical Peels
	Excessive underarm sweating
	Micro-needling
	Thinning eyelashes/Latisse
	Weight Management
	Antioxidant, Vitamin, Anti-inflammatory infusions
	Other:

Describe your current skin care regimen.

Morning
Evening

Medical History

List any cosmetic procedures that you have had.

Previous Surgery

Allergies to medications or foods:

Allergy	Reaction

Daily Medications: Please include all over-the-counter, herbal and prescription medications.

Name of medication and dosage	

YES / NO	Have you recently taken any blood thinner medicine? This would include: Aspirin, Ibuprofen, Aleve, Tylenol, fish oil, vitamin E or D, turmeric, Coumadin, Xarelto, Savaysa, Pradexa, Eliquis, Lovenox.
YES / NO	Do you have a diagnosed bleeding disorder?
YES / NO	Are you pregnant, planning to become pregnant, or nursing?
YES / NO	Do you have a history of scarring or keloids?
YES / NO	Do you have a history of hyperpigmentation/skin darkening?
YES / NO	Do you have a history of or acute breakout of cold sores or fever blisters?
YES / NO	Have you taken Accutane (isotretinoin) in the past 12 months?
YES / NO	Are you very sensitive to being in the sun?
YES / NO	Have you had any recent skin infections?
YES / NO	Have you ever had a life-threatening reaction to any medicine, food, or anything else?
YES / NO	Do you have a history of lupus or any other connective tissue disease?
YES / NO	Have you been diagnosed with any neurologic disorders such as Eaton-Lambert syndrome or Myesthenia Gravis
YES / NO	Are you currently taking aminoglycosides, penicillamine, quinine, or calcium channel blockers?

ACKNOWLEDGEMENT OF PRIVACY PRACTICES

My signature confirms that I have been informed of my rights to privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA). I understand that this information can and will be used to:

- Provide and coordinate my treatment among a number of health care providers who may be involved in that treatment directly and indirectly
- Obtain payment from third party payers for my health care services
- Conduct normal healthcare operations such as quality assessment and improvement activities

I have been informed of my medical provider's Notice of Privacy Practices containing a more complete description of the uses and disclosures of my protected health information. I have been given the right to review and receive a copy of such Notice of Privacy Practices. I understand that my medical provider has the right to change the Notice of Privacy Practices and that I may contact this office at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or healthcare operations and I understand that you are not required to agree to my requested restrictions, but if you do agree than you are bound to abide by such restrictions.

Patient Name: _____ Date: _____

Signature: _____