RBI
REGENERATIVE BIOLOGICS
& AGE MANAGEMENT INSTITUTE

AESTHETICS CENTER
NEW PATIENT INFORMATION

Patient Name: _____ What name do you prefer to be called? _____

Local Address: _____ _____
(CITY, STATE, ZIP)

Alternate Address: _____ _____
(CITY, STATE, ZIP)

What Months are you at alternate address? From: _____ To: _____

PHONE NUMBERS: (We should have at least one way to reach you about appointments)

Local: (_____) _____ - _____ May we leave a message at this number? ❑ Yes ❑ No

Cellular: (_____) _____ - _____ May we leave a message at this number? ❑ Yes ❑ No

Alternate: (_____) _____ - _____ May we leave a message at this number? ❑ Yes ❑ No

Please note any special phone instructions (including hours): _____

EMAIL: (We hate spam and will never give your email address out to other businesses or individuals.)

Primary: (_____) _____ - _____ Alternate: (_____) _____ - _____

May we send you announcements and specials from RBI? ❑ Yes ❑ No (We expect to send out 1-2 such emails per month on average.)

Please note any special email instructions: _____

Patient Date of Birth: _____/_____/_____ Sex: ❑ M ❑ F

Emergency Contact Name: _____ Phone Number: (_____) _____ - _____

Marital Status: _____ Spouse's Name: _____ Spouse's Date of Birth: _____

HOW DID YOU HEAR ABOUT US? Please include names.

❑ Patient: _____ ❑ Seminar

❑ Family / Friend: _____ ❑ Our Website

❑ Referred by M.D.: _____ ❑ Other Website _____

❑ Newspaper - Name: _____ ❑ Yellow Pages

❑ Radio - Station Name: _____ ❑ Spa/Gym

❑ Other (Please Specify): _____

Would you like to be notified about upcoming seminars, new information, products and services? ❑ Yes ❑ No
Do you prefer regular mail, email or both?

I'M INTERESTED IN: (please check all that apply):

❑ Wrinkle Reduction	❑ Improve Skin Folds and Creases	❑ Brown / Age Spot Removal	❑ Dermal Fillers
❑ Improved Skin Texture	❑ Botox / Xeomin	❑ Reduce Redness	❑ Other (please specify)
❑ Lip Enhancement	❑ Skin Care Products	❑ Skin Tightening	_____

Is there anything else we should know about you? _____

_____

DO NOT WRITE BELOW THIS LINE - FOR OFFICE USE ONLY

Account Number: _____

Date Registered: _____ Registered By: _____

MEDICAL HISTORY AND CONSULTATION FORM (to be completed by patient prior to physician review)

Name: _____ Today's Date: _____

Age: _____ Date of Birth: _____/_____/_____ Regular Physician: _____

Sex: ❑ M ❑ F Do you smoke? ❑ Yes ❑ No

Allergies (including any local anesthetics):_____

Current Medications (include hormones, OTC meds, Vitamins and Herbal remedies): _____

_____

_____

SCREENING QUESTIONS - PLEASE CIRCLE AND PROVIDE DETAILS:

- ❑ Pregnant, breast-feeding or planning on either
- ❑ History of cold sores / fever blisters / oral herpes
- ❑ Use of blood thinners such as coumadin, plavix or aspirin
- ❑ Recent use of fish oil, garlic, Vitamin E or other herbal treatments that can increase bleeding
- ❑ Easy bleeding or bruising
- ❑ Current use of Arnica Montana (found in health food stores and helps to reduce bruising)
- ❑ Previous cosmetic surgery (including face lift or implants)
- ❑ Previous use of dermal fillers (such as Juvederm, Radiesse, Perlane, Restalyne)
- ❑ Previous Botox or Dysport
- ❑ Previous permanent make-up
- ❑ Recent prolonged sun exposure or tanning bed use
- ❑ If here for hair removal, recent waxing, plucking or electrolysis
- ❑ Keloids or excessive scarring
- ❑ Accutane use in past. (Date last used if within 6 months _____)
- ❑ Gold therapy ever received for arthritis or other conditions
- ❑ Use of Retin-A (tretenoin) or hydroquinone
- ❑ History of vitiligo (large white patches on skin)
- ❑ History of melanoma or other skin cancer
- ❑ History of SLE (lupus) or other auto-immune diseases
- ❑ History of immunodeficiency or use of immunosupressive drugs
- ❑ History of hepatitis or HIV
- ❑ Myasthenia Gravis, ALS, Lambert Eaton syndrome or neuropathy
- ❑ Mitral Valve Prolapse (MVP)
- ❑ Implanted pacemaker or defibrillator
- ❑ Use of antibiotics prior to routine dental work being done

OTHER MEDICAL HISTORY: (Please include any medical conditions being followed by a physician): _____

_____

_____

_____

_____

AESTHETIC CONCERNS TODAY:_____

_____

I certify that the above information is complete, with no omissions, and is correct to the best of my knowledge.

Patient Signature: _____