NRG

PATIENT REGISTRATION and MEDICAL HISTORY FORM 2-26-26

First Name	Middle Name	Last Name	Preferred Name

Home Street Address	City	State	Zip Code

Telephone--Cell	Telephone--Home	Sex Assigned at Birth
		☐ Male ☐ Female

May we send you text message Appointment Reminders and customer care messaging? See page 4.	May we call you to remind you of your appointment?
☐ Yes ☐ No	☐ Yes ☐ No

What is your Ethnicity?	Social Security Number for tax purposes
☐ Not Hispanic/ Latino ☐ Hispanic/ Latino	

What is your Race (Select all that apply)? ☐ White ☐ Black or African American ☐ American Indian or Alaska Native

☐ Asian, If Asian check all that apply: ☐ Asian Indian ☐ Chinese ☐ Filipino ☐ Japanese

☐ Hawaiian or Other Pacific Islander ☐ Other_____

Primary Care Physician/ Provider Information

Physician Name	Physician Address	Physician Phone Number

Emergency Contact Information

Contact #1 May we release medical information to this contact? ☐ Yes ☐ No

First & Last Name	Relationship	Cell phone

Contact #2 May we release medical information to this contact? ☐ Yes ☐ No

First & Last Name	Relationship	Cell phone

MEDICAL HISTORY

Allergy History ☐ No allergies

Allergy	Reaction
Latex ☐ No ☐ Yes	

For Females

Date of last period:_____ ☐ **Post-menopausal** for _____months _____years

☐ **Pregnant** ☐ **Planning pregnancy** ☐ **Breastfeeding**

Method of Birth Control:

☐ Birth control pills ☐ IUD_____ ☐ Bilateral ovaries removed

☐ Implantable hormone device ☐ Birth control patch ☐ Bilateral tubal occlusion ☐ Hysterectomy

☐ Depo-Provera injections ☐ Sexual Abstinence ☐ Bilateral tubal ligation ☐ Vasectomy of partner

Medical History

Patient Name_____

Have you EVER had or still have any of the following? If yes, please specify. ☐ NA

Condition	Details & Date diagnosed	Condition	Details & Date diagnosed
☐ High Blood Pressure		☐ Osteoporosis/ osteopenia	
☐ High Cholesterol		☐ HIV	
☐ Heart attack		☐ Hepatitis A , B or C	
☐ Congestive heart failure		☐ Herpes, genital or mouth	
☐ Coronary artery disease		☐ Warts	
☐ Heart murmur or heart valve problem		☐ Crohn's disease or ulcerative colitis	
☐ Heart arrhythmia		☐ Heartburn or reflux	
☐ Diabetes		☐ Ulcers	
☐ Kidney problems		☐ Anxiety or panic attacks	
☐ Liver disease or cirrhosis		☐ Depression	
☐ Hernia		☐ ADHD, ADD	
☐ Thyroid problems		☐ Insomnia	
☐ Arthritis-what type		☐ Sleep apnea	
☐ Rheumatology problems		☐ Hearing loss	
☐ Gout		☐ Ear problems	
☐ Blood transfusion		☐ Eye problems	
☐ Anemia		☐ Headaches or migraines	
☐ Blood clot/ DVT		☐ Epilepsy or seizures	
☐ Bleeding disorder		☐ Stroke or paralysis	
☐ Asthma		☐ Neurologic problems	
☐ Tuberculosis or positive TB test		☐ Drug or alcohol dependency or abuse	
☐ Acne		☐ Other	
☐ Eczema		☐ Other	
☐ Psoriasis		☐ Other	
☐ Seasonal allergies, hayfever		☐ Other	
☐ Lung problems		☐ Other	
☐ Skin cancer/ pre-cancer: ☐ Melanoma ☐ Basal cell carcinoma ☐ Squamous cell Carcinoma ☐ Actinic keratoses		☐ Cancer or tumor (what type, how treated, when?)	

☐ Must take antibiotics before dental procedures due to a heart murmur, heart valve or artificial joint? ☐ No ☐ Yes

Procedures and Surgical History ☐ NA

Procedure/ Surgery	Date	Procedure/ Surgery	Date
☐ Appendectomy		☐ Heart bypass	
☐ Gallbladder removal		☐ Wisdom teeth	
☐ Artificial joint		☐ Vasectomy	
☐		☐	
☐		☐	

Medications & Supplements (current and in **last 30 days**) **Patient Name**_____ ☐ NA

Name	Dose	Times per day	Start Date	End Date	Reason for taking

Have you had any COVID-19 Vaccines? ☐ No ☐ Yes

If yes, which ones: ☐ Pfizer ☐ Moderna ☐ Johnson and Johnson

Dates of COVID-19 vaccines:_____

Substance Use History

Substance	Use	**Frequency** (ie 1 pack per day or 3 cans/ month)
Alcohol	☐ Current ☐ Former ☐ Never	
Tobacco, type:	☐ Current ☐ Former ☐ Never	
Caffeine	☐ Current ☐ Former ☐ Never	
Other:	☐ Current ☐ Former ☐ Never	

Aesthetic History ☐ NA

	Most Recent Date
☐ Eyelid surgery (blepharoplasty) or brow lift 5 y	
☐ Face lift	
☐ Myasthenia gravis, Eaton-Lambert syndrome, ALS (Lou Gerig Disease)	
☐ Microblading/ tattoo of eyebrows 6m	
☐ Any Botulinum Toxin (such as Botox, Dysport, Jeuveau, Xeomin, Daxify, study drug botulinum toxin) 9m	
☐ **Non-permanent** fillers (hyaluronic acids such as Juvederm, Restylane; Radiesse; Sculptra) 1y GL	
☐ **Permanent** fillers (silicone), lifting threads, autologous fat or permanent procedures GL	
☐ Laser treatment 3m	
☐ Microneedling 3m	
☐ Facial skin resurfacing including dermabrasion, laser, chemical peel 1y	
☐ Facial nerve palsy	
☐ Oral retinoids like Accutane, isotretinoin, Soriatane, acitretin 1m	
☐ Topical retinoids like tretinoin, Retin-A, Differin, adapalene, Tazorac, tazarotene	

Other

☐ Yes	☐ No	Any planned hospitalizations?
☐ Yes	☐ No	Any planned surgeries?
☐ Yes	☐ No	Are you currently in a clinical study?
☐ Yes	☐ No	Have you ever been in a clinical study? When and what type?

Pharmacy

Name:	**Phone:**	**Address:**

Patient Name_____

How did you hear about us?

☐ Phone call from us ☐ Email from us ☐ Text from us ☐ Newspaper ☐ Radio ☐ Our website
☐ Facebook/ social media ☐ Family/ Friend ☐ Doctor/ Nurse: Name_____

Consent Form:

I consent to receiving customer care-related text messages or emails from Nash Research Group. Message and data rates may apply. Carriers are not liable for delayed or undelivered messages. Message frequency varies per user. Reply STOP to unsubscribe. Please refer to our Privacy Policy and Terms and Conditions.

☐ Yes ☐ No _____ _____
Patient Signature Date

Without any identifiers to my personal information, my demographic data may be used for educational, informational, or statistical purposes.

☐ Yes ☐ No _____ _____
Patient Signature Date

I consent to receiving promotional text messages, emails, or phone calls from Nash Research Group concerning future research studies for which I may be eligible. Message and data rates may apply. Carriers are not liable for delayed or undelivered messages. Message frequency varies per user. Reply STOP to unsubscribe. I may request at anytime to have my name removed from this database. Please refer to our Privacy Policy and Terms and Conditions.

☐ Yes ☐ No _____ _____
Patient Signature Date

Our preferred method of paying you is through Zelle**.**
May NRG pay you through Zelle? ☐ Yes ☐ No (If no, you will be paid with a live check.)

Notice of Privacy Practices

I have reviewed or have been offered to review a copy of the NRG Privacy Policies. I understand that I may obtain a copy by request. Any questions regarding this form have been answered.

_____ _____
Patient Signature Date

_____
Patient Printed Name

_____ _____
Witness Signature Date

_____
Witness Printed Name