

PATIENT REGISTRATION FORM 9-29-26

First Name	Middle Name	Last Name		Preferred Name
Home Street Address	City	State	Zip Code	Sex Assigned at Birth ☐ Male ☐ Female
Telephone—Cell	Email address			Date of Birth:
What is your ethnicity? ☐ Not Hispanic/ Latino ☐ Hispanic/ Latino				Age:
What is your Race? (Select all that apply) ☐ White ☐ Black ☐ American Indian or Alaska Native ☐ Japanese ☐ Asian ☐ Native Hawaiian or Other Pacific Islander ☐ Other _____				

Primary Care Physician Information

Physician Name:

Physician Phone Number:

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

First & Last Name	Telephone
Relationship	Alternate Phone

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

First & Last Name	Telephone
Relationship	Alternate Phone

MEDICAL HISTORY**Allergy History**☐ NA

Allergy	Reaction

For Females

Date of last period: _____ ☐ Post-menopausal as of what date? _____
☐ Pregnant ☐ Planning pregnancy ☐ Breastfeeding
Method of Birth Control: ☐ Birth control pills ☐ IUD _____ ☐ Vasectomy of partner
☐ Implantable hormone device ☐ Birth control patch ☐ Bilateral tubal occlusion ☐ Hysterectomy
☐ Depo-Provera injections ☐ Sexual Abstinence ☐ Bilateral tubal ligation ☐ Bilateral ovaries removed

Have you had any COVID-19 Vaccines? ☐ No ☐ YesIf yes, which ones: ☐ Pfizer ☐ Moderna ☐ Johnson and Johnson

Dates of COVID-19 vaccines: _____

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		☐ Lung problems	
☐ 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		☐ Depression	
☐ Kidney problems		☐ Anxiety or panic attacks	
☐ Liver disease or cirrhosis		☐ ADHD, ADD	
☐ Hernia		☐ Eye problems	
☐ Thyroid problems		☐ Vision loss	
☐ Arthritis-what type		☐ Sleep apnea	
☐ Rheumatology problems		☐ Hearing loss	
☐ Gout		☐ Ear problems	
☐ Blood transfusion		☐ Headaches or migraines	
☐ Anemia		☐ Seasonal allergies	
☐ 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	
☐ Eczema		☐ Acne	
☐ Psoriasis		☐ Facial nerve palsy	
☐ Osteoporosis/ osteopenia		☐ Radiation to the mid or upper face	
☐ Skin cancer/ pre-cancer: ☐ Melanoma ☐ Basal cell carcinoma ☐ Squamous cell Carcinoma ☐ Actinic keratoses		☐ Neurologic problem ☐ Multiple sclerosis ☐ Myasthenia gravis ☐ Eaton-Lambert syndrome ☐ ALS (Lou Gerig Disease)	
☐ Other		☐ Cancer or tumor (what type, how treated, when?)	

Have you lost any weight in the last 6 months? ☐ No ☐ Yes, if yes, how many pounds? _____**Procedures and Surgical History**☐ NA

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

Patient Name_____ ☐ NA

Name	Dose	Times per day	Start Date	End Date	Reason for taking
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Frequency (ie 1 pack/ day)

☐ Current: start date_____ ☐ Former: stop date_____☐ NA **Most Recent Date**☐ Other:

☐ Filler such as Juvederm, Restylane; Radiesse; Sculptra: where? _____

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:

Pharmacy #:

Address:

How did you hear about us?

- ☐ Phone call from us ☐ Email from us ☐ Text from us ☐ Our website ☐ Facebook/ social media
- ☐ Family/ Friend ☐ Doctor/ Nurse Name of person referring you: _____
- ☐ Other _____

Consent Form: Permission to Contact for Future Trials

I hereby give my permission to have my name and demographic information placed in a database that is maintained and used by Nash Research Group (NRG). NRG may contact me if it feels I may be eligible for another research trial. These research studies are always approved by Regulatory Agencies and Research Ethics Boards. Your information will never be sold.

☐ Yes ☐ No_____
Patient Signature_____
Date

By signing this information sheet, I am not agreeing to participate in a clinical trial, and I may request at anytime to have my name removed from this database.

Our preferred method of paying you is through Zelle. Please set up Zelle through your bank on your phone. If your bank does not have Zelle, 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