AEON AESTHETICS & GYNECOLOGY
where beauty and health are timeless

Patient Intake Forms

Welcome to our office! Please fill out all of our forms

Name: _____ Date of Birth: _____ Today's Date: _____

Address: _____
(street) (city) (state) (zip code)

Home Phone: _____ Cell Phone: _____

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

If the patient is a minor, name of parent: _____

Phone # of parent: _____ Work # of parent: _____

Pharmacy Information

Pharmacy Name: _____ Pharmacy Phone #: _____

How would you like to be contact by our office for appointment updates:

☐ Email ☐ Text ☐ Phone ☐ Mail

Please read: All copayments are due at the time of appointment. We accept cash or credit/debit card for all copayments, no personal checks. All lab work performed in office will be sent to an offsite location for testing; cost of lab work is not included in copay and will be billed (if applicable) directly from the laboratory. Please sign below stating that you have read the above.

Patient Signature: _____ Date: _____

If patient is a minor, signature of responsible party: _____

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PATIENT HEALTH HISTORY FORM

Name: _____ Date: _____

Height: _____ Weight: _____

Allergies: _____

Medication you are currently taking: _____

Herbal supplements (if any): _____

Health History

Date of last physical exam: _____ By Dr: _____ (or Practice name)

Date of last flu immunization: _____

Are you pregnant: _____Nursing: _____

First date of your last menstrual period: _____

List all major surgeries: _____

	Check if yes		Check if yes
Heart disease (skipping, heart attack, etc)		Gastrointestinal Disease (ulcer, GERD, etc)	
High Blood pressure		Mental Health Issues (depression, anxiety, etc)	
Lung Disease (asthma, bronchitis, etc)		Autoimmune Disorders known to cause sensitivity to light	
Liver Disease (jaundice, hepatitis, etc)		History of cold sores or fever blisters/ herpes	
Kidney disease		Neuromuscular Disorders	
Diabetes		Reveiving or received immunosuppressant therapy	
Thyroid Disease		History of skin cancer or suspicious lesions	
Blood Disease (anemia, sickle cell, etc)		History of seizures triggered by light	
Neurological Disease (TIA, stroke, etc)		Are you currently taking aspirin, blood thinners, NSAIDs (ibuprofen, Aleve, etc)	
Do you have heavy periods		Do you have a history of ovarian cysts or uterine fibroids	
Have you ever had a blood clot			

Please indicate if you have any of the following medical conditions:

Do you smoke? If yes, how much: _____Do you have an allergy to latex? _____

Do you have prosthetics/devices in your body? _____

By signing below, I affirm that all the above information is valid and truthful.

Patient signature:_____

Nurses Signature:_____

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HIPAA ACKNOWLEDGEMENT/ CONSENT FORM

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment)
- Obtaining payment from third party payers (e.g. my insurance company);
- The day-to-day healthcare operations of your practice.

I have also been informed of and given the right to review and secure a copy of your Notice of Privacy Pratices, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Print Patient Name _____

Signature _____ Date _____

Relationship to Patient (if patient unable to sign or a minor) _____

I prefer that I be contacted by phone at: _____

I prefer that any mail addressed to me be sent to:

_____

I authorize the following person(s) to take phone messages (if none, indicate none): _____

_____

Relationship to patient: _____