Patient Registration Form

Last Name

Please input Last name

First Name:

Please input First name

Date of Birth:

Please input Date of Birth

Address Line 1:

Address Line 2:

City:

State:

Zip:

Cell Phone:

Please input Client Phone

Home Phone:

Work Phone:

Email (required):

Please input Client E-mail

Sex:

- ◯ F
- ◯ M
- ◯ Other

Marital Status:

- ◯ Single
- ◯ Separated
- ◯ Widowed
- ◯ Married
- ◯ Divorced

Social Security #:

Occupation:

Employer

City/State

Pharmacy Information

Patient Registration Form

Pharmacy Name:

Pharmacy Phone Number:

Pharmacy Address:

How did you find out about us?

- [ ] Website
- [ ] Facebook
- [ ] Doctor Referral
- [ ] Google
- [ ] RealSelf
- [ ] Family/Friend
- [ ] Instagram
- [ ] Yelp

Other:

Referring Physician (if applicable)

Referring Physician specialty (if applicable)

Primary Care Physician:(If other than referring Physician)

PCP Phone:

Emergency Contact

Name:

Relationship to client:

Best contact #:

Medical History

Have you ever been treated for any of the following?

	Yes	No
High Blood Pressure	◯	◯
Heart Murmur	◯	◯
Heart Attack	◯	◯
Cancer	◯	◯
Diabetes	◯	◯
Bleeding Disorder	◯	◯
Seizures	◯	◯
Stroke	◯	◯
Blockage of Arteries	◯	◯
Swelling (Edema)	◯	◯
Thyroid Disorder	◯	◯
Shortness of breath	◯	◯
Eye Disease	◯	◯
Hepatitis	◯	◯
HIV/AIDS	◯	◯
Sexually Transmitted Disease	◯	◯
History of Anxiety/Depression	◯	◯
Skin Disease	◯	◯
Frequent Infections/Boils	◯	◯

Allergies:

Medical Surgical History:

Plastic Surgery History:

Allergic Reaction to GENERAL Anesthetic?

- ◯ Yes
- ◯ No

Allergic Reaction to LOCAL Anesthetic?

- ◯ Yes
- ◯ No

Medication list:

Diet:

- ☐ Regular
- ☐ Low Salt
- ☐ Vegetarian
- ☐ Weight Loss
- ☐ No Added Salt
- ☐ Diabetic
- ☐ Low Fat/Cholesterol
- ☐ Low Carb
- ☐ Renal

Alcohol use?

- ◯ Yes
- ◯ No

Exercise

- ☐ Sedentary
- ☐ Occasional
- ☐ Aerobics
- ☐ Physically Unable
- ☐ Regular
- ☐ Active Lifestyle
- ☐ Weight Lifting

Recreational Drugs

- ◯ Yes
- ◯ No

Type:

Tobacco Use?

- ◯ Yes
- ◯ No

Packs/Day:

For how many years have you smoked?

Males Only

Last Urology Exam

Last Colonoscopy

Last Fecal Occult Blood Test

Flu vaccine:

Females Only

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	Yes	No
Are you pregnant or considering becoming pregnant in the future?	◯	◯
Are you breastfeeding?	◯	◯

Number of pregnancies:

Number of deliveries:

Age of children (if applicable):

Birth control method:

Last Pap Smear:

Last Mammogram:

Last Bone Density:

Do you have any of the following conditions:

	Yes	No
Pelvic Pain	◯	◯
Uterine Fibroids	◯	◯
More painful legs during menstruation	◯	◯

Covid Vaccination Status

☐ Fully Vaccinated ☐ Partially Vaccinated ☐ Not Vaccinated

Please Read This Form Carefully and Completely Before Signing It

I, , understand, have read and completed this questionnaire truthfully. I agree that this constitutes full disclosure, and that it supersedes any previous verbal or written disclosures. I understand that withholding information or providing misinformation may result in contraindications and/or irritation from treatments received. I am aware that it is my responsibility to inform Dr. Verbin of my current medical or health conditions and to update this history. The treatments I receive here are voluntary and I release South Bay Aesthetics from liability and assume full responsibility thereof.

I understand that it is not practical to list every aspect of medical care, nor every procedure or treatment which I might receive. However, I acknowledge that my doctor is available to answer my questions I might have. I understand that the practice of medicine and surgery are not exact sciences, and acknowledge that no guarantee or assurance has been made to me as a result of treatments or examination.

I certify that I have read this form, and had it explained to me, and certify that I fully understand its contents.

SOUTH BAY aesthetics PLASTIC SURGERY
DR. CHRISTOPHER VERBIN

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02/09/2023

Financial Responsibility Agreement

THE UNDERSIGNED agrees whether he/she signs as parent, spouse, guarantor, guardian, or patient, that in consideration of the services to be rendered to the patient, he/she hereby individually obligates himself/herself to pay the account. Should the account be referred to an attorney for collection, I authorize attorney to obtain my credit report: and the undersigned shall pay reasonable attorney's fees and collection expenses.

Authorization to Release Photographs and Treatment Details

I give permission to to photograph the areas I would like treated, both before and after treatment/procedure. I understand these photographs will be used to monitor the progress of my treatments and may be used for other medical purposes. I understand that if used for medical research purposes these photographs will not contain my name or other identifying information, and I understand that I will not be entitled to any payment or other forms of remuneration as a result of any use of the photographs. If my pictures are wanted for marketing purposes, South Bay Aesthetics will discuss and re consent me for such.

I also grant consent to to send and disclose all before and after photos of my evaluations and procedures as well as treatment details and progress notes to my primary health care physician if needed.

02/09/2023