Fresh Face Studio, LLC
18 Park Street
Gorham, NH 03581

PATIENT REGISTRATION:

Patient's Name:_____Birth Date:_____

Mailing Address: _____

City:_____State:_____Zip:_____Home Phone Number:_____

Employer:_____Work Phone Number: _____

Email Address:_____ Cell Phone Number: _____

Preferred method of contact:_____

Marital Status: ____Name of Spouse: _____ Birth Date:_____

If a Minor, Guardian's Name and relationship: _____

Emergency Contact:_____Relationship_____Phone #_____

Responsible Party's Name:_____Birth Date: _____

Responsible Party's Address:_____

City:_____State:_____Zip:_____Phone Number_____

PURPOSE OF THIS APPOINTMENT:_____
Whom may we thank for referring you?_____

Cancellation Policy: Fresh Face Studio, LLC. views all appointments as a commitment between our patients and us. If you are unable to honor the commitment, we request 2 business days notice to allow another patient who is waiting for that time to be scheduled. If two appointments are not kept without the patient giving 2 business days notice in a twelve-month period the patient agrees to pay a fee equal to the greater of $50 or 15% of the cost of the planned treatment. If three appointments are not kept without the patient giving 2 business days' notice in a twelve-month period, Fresh Face Studio, LLC reserves the right to terminate the patient-doctor relationship.
Financial Policy: Payment is due when services are rendered.

_____

Signature of Responsible Party Date

HEALTH HISTORY:

The following questions are for our records only. They are considered confidential and will become part of your permanent record.

Please circle YES or NO for each question. If in doubt, leave blank.

1. Are you in good health? ..... YES NO
2. Has there been a change in your health within the last year ..... YES NO
3. Are you presently under the care of a physician? ..... YES NO
4. **WOMEN:** Are you pregnant? If yes, how far along? _____
5. Do you use tobacco in any form? If yes, how much? _____
6. Do you use alcoholic beverages (more than 2 drinks daily) _____

Do you have or have you had any of the following?

GENERAL
Tire easily, weakness ..... YES NO
Marked weight change ..... YES NO
Night sweats ..... YES NO
Persistent fever ..... YES NO

SKIN
Eruptions (rash) hives ..... YES NO
Change in skin color ..... YES NO

EYES
Visual change ..... YES NO
Glaucoma ..... YES NO

EARS
Loss of hearing ..... YES NO
Ringing in ears ..... YES NO

NOSE
Frequent nose bleeds ..... YES NO
Sinus Problems ..... YES NO

THROAT
Soreness/hoarseness ..... YES NO

NERVOUS SYSTEM
Stroke ..... YES NO
Headaches ..... YES NO
Convulsions/Epilepsy ..... YES NO
Numbness/tingling ..... YES NO
Dizziness/fainting ..... YES NO
Psychiatric Treatment ..... YES NO

NEUROMUSCULAR CONDITIONS …...YES NO

RESPIRATORY
Tuberculosis ..... YES NO
Emphysema ..... YES NO
Asthma/hay fever ..... YES NO
Persistent cough ..... YES NO
Sputum production ..... YES NO
Cough up bloody sputum ..... YES NO
Difficulty breathing while lying down ..... YES NO
History of Sinus Infection ..... YES NO

ENDOCRINE
Diabetes ..... YES NO
Family history of diabetes ..... YES NO
Thyroid condition/goiter ..... YES NO

OTHER CONDITIONS _____
_____
_____

HEART/BLOOD VESSELS
Rheumatic Fever ..... YES NO
Heart Murmur ..... YES NO
Chest pain/discomfort ..... YES NO
Heart Attack/trouble ..... YES NO
Shortness of breath ..... YES NO
Swelling of ankles ..... YES NO
High Blood Pressure ..... YES NO
Congenital Heart Disease ..... YES NO
Mitral Valve Prolapse ..... YES NO
Artificial heart valve ..... YES NO
Pacemaker ..... YES NO
Heart Surgery ..... YES NO
Other _____

BONE/MUSCLE
Arthritis/rheumatism ..... YES NO
Artificial joints or limbs ..... YES NO
Placement of Pins or rods ..... YES NO

DIGESTIVE SYSTEM
Hepatitis ..... YES NO
Jaundice ..... YES NO
Ulcers ..... YES NO
Change in appetite ..... YES NO

URINARY
Kidney Disease ..... YES NO
Increased urine production ..... YES NO
Burning on urination ..... YES NO
Urethral discharge ..... YES NO
Bloody Urine ..... YES NO
Venereal Disease ..... YES NO

BLOOD
Bruise easily ..... YES NO
Anemia ..... YES NO
Blood Transfusion ..... YES NO

OTHER
Radiation therapy ..... YES NO
Chemotherapy ..... YES NO
Tumors or growths ..... YES NO
Cancer ..... YES NO
HIV or AIDS ..... YES NO

HEALTH HISTORY:

10. Are you **ALLERGIC** to or have you experienced a reaction to any of the following?

Local Anesthesia (e.g. Novocain)	YES	NO	Aspirin or Codeine	YES	NO
Barbiturates/sedatives/sleeping pills	YES	NO	Sulfa Drugs	YES	NO
Penicillin	YES	NO	Other allergies_____		

11. Are you **CURRENTLY TAKING** any of the following medications?

Antibiotics/Sulfa drugs	YES	NO	Insulin/other diabetes drug	YES	NO
Blood thinners	YES	NO	**Osteoporosis medication**	YES	NO
Blood pressure medications	YES	NO	Digitalis/other heart medication	YES	NO
Cortisone/steroids	YES	NO	Nitroglycerin	YES	NO
Antihistamine/allergy drugs/cold medications	YES	NO	Aspirin	YES	NO
Tranquilizers	YES	NO	Hormones……..	YES	NO

Other supplements like GARLIC – GINGER – GINKGO – FISH OIL – OMEGA 3 – COQ10 – FLAXSEED – VIT E – LICORICE – CAYENNE -

12. Please list any medications (prescription and non-prescription) and the dosage that you take regularly or apply to your face:

_____

_____

_____

_____

13. Do you have or have you had any of the following

MOUTH (Lip Patients)

Bleeding sore gums	YES	NO	Burning tongue/lips	YES	NO
History of cold sores/past or present	YES	NO	Frequent blisters, lips/ mouth	YES	NO
Difficulty opening/closing jaw	YES	NO	Clicking/popping jaw	YES	NO

FACE AND NECK

Have you ever had BOTOX – DYSPORT – XEOMIN – JUVEAU ……	YES	NO
Fillers: JUVEDERM – RESTYLANE – VERSA – BELOTERO - SCULPTRA……	YES	NO
Facial Implants: Cheek – Chin – Nose, etc……	YES	NO
Threads: ……	YES	NO
Radiofrequency Treatments (Skin Tightening – Body Recontouring ……	YES	NO
IPL or LASER Treatments ……	YES	NO
Microneedling ……	YES	NO
Peels ……	YES	NO
Tanning salons ……	YES	NO
Face Lift ……	YES	NO
Surgical procedures on the face (mole removal, skin cancer removal) ……	YES	NO
Keloid Scarring ……	YES	NO
Any COMPLICATIONS with any Facial Esthetic Procedures ……	YES	NO

TMJ – OROFACIAL PAIN – HEADACHES …… YES NO

To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any changes in my health or changes in my medications, I will inform my provider at the next appointment.

_____

Signature of Patient, Parent, or Responsible Party DATE