Transformations Med Spa L.L.C.

36 South Road, Somers, CT, 06071
(860) 265-3327

Patient Information

Patient Name _____ Date of Birth _____ Age _____

Marital Status S M D W Sex M F

Address _____ Home (_____) _____

City _____ State _____ Zip _____ Cell (_____) _____

Employer _____ Work (_____) _____

Address _____ City _____ State _____ Zip _____

Email: _____

Emergency Contact

Name _____ Relationship to you _____

Home (_____) _____ Work (_____) _____

Referred By (Circle all that apply-use the corresponding space to elaborate)

Patient _____ Public Seminar _____
Physician _____ Advertisement _____
Internet Website _____ **Other :** _____

Interest/Concern (By circling below I am authorizing TMS to provide information or services)

Aging Face (Non-surgical)	Injectable Fillers	Skincare Services/Products
Forehead Lift (Non-surgical)	Botox/Dysport	Laser Services
Vascu Treatment	Cryo Treatment	Educational Programs/Events

Other _____

Patient Signature _____ Date _____

NAME: _____DATE: _____
DATE OF BIRTH:_____

Who is your Primary Care Physician? _____
Who is your Dermatologist / Esthetician? _____

Have **YOU** or any *RELATIVES* had problems with any of the following conditions?

	MYSELF		*RELATIVE*		(What relationship?)
Heart disease	**Yes**	**No**	*Yes*	*No*	_____
High Blood Pressure	**Yes**	**No**	*Yes*	*No*	_____
Diabetes	**Yes**	**No**	*Yes*	*No*	_____
Stroke	**Yes**	**No**	*Yes*	*No*	_____
Excessive Bleeding	**Yes**	**No**	*Yes*	*No*	_____
Excessive Bruising	**Yes**	**No**	*Yes*	*No*	_____
Poor healing	**Yes**	**No**	*Yes*	*No*	_____
Excessive Scarring	**Yes**	**No**	*Yes*	*No*	_____
Cancer	**Yes**	**No**	*Yes*	*No*	_____
Skin Cancer	**Yes**	**No**	*Yes*	*No*	_____
Glaucoma	**Yes**	**No**	*Yes*	*No*	_____

Please Explain any "Yes" answers here:_____
_____

Do you have a history of sunburns in childhood?	YES	**NO**
Do you have a heart murmur?	YES	**NO**
Do you have any artificial joints?	YES	**NO**
Do you have chest pain or pressure?	YES	**NO**
Do you have high cholesterol?	YES	**NO**
Do you have asthma or lung problems?	YES	**NO**
Do you have seasonal or environmental allergies?	YES	**NO**
Do you have any thyroid problems?	YES	**NO**
Do you have liver problems?	YES	**NO**
Have your ever had hepatitis? Type A , B, or C ?	YES	**NO**
Have you ever had a seizure or convulsions?	YES	**NO**
Do you have problems with your eyes (besides glasses)?	YES	**NO**
Is any part of your body paralyzed or numb?	YES	**NO**
Do you have any kidney problems?	YES	**NO**
Do you have anemia or any problems with your blood?	YES	**NO**
Have you ever had a blood transfusion?	YES	**NO**
Have you ever had cold sores, or fever blisters?	YES	**NO**
Do you have a history of dry eyes?	YES	**NO**
Women:		
Are you, or could you be pregnant?	YES	**NO**
Are you breast feeding?	YES	**NO**
Do you wear hearing aids?	YES	**NO**
Have you been diagnosed with MRSA?	YES	**NO**

Please list any other medical problems that have not been covered _____

_____

_____

Please list all past surgeries / operations:_____

_____

_____

Do you take any medications, including birth control pills or aspirin? YES NO
Please list: _I do have an IUD_____

_____

_____

_____

Do you take vitamins, over the counter medications, or herbal supplements? YES **NO**
Please list: _____

_____

Have you taken steroid medication in the last year? YES **NO**
Have you ever taken the medication Accutane? YES **NO**
Are you allergic to any medications? YES **NO**
If yes, what medication and what was the reaction? _____

_____

_____

Do you have a sensitivity / allergy to latex? YES **NO**
Do you have a sensitivity / allergy to tape? YES **NO**
Do you smoke? How Much? _____ YES **NO**
Do you use recreational drugs? YES **NO**
Do you drink alcohol? How much? __Twice a week, socially _____ **YES** NO

Consent for Release of Information/Assignment of Benefits

I authorize Transformations Medical Spa to release any information pertaining to my diagnosis and treatment to my Primary Care Physician(s).

I understand that if insurance coverage is applicable, I authorize payment of medical benefits Transformations Medical Spa for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the release of any medical information necessary to process the claim and secure payment of benefits.

Signed:_____**Date:**_____
PATIENT SIGNATURE

The initial consultation was performed and confirmed with the patient.

Signed:_____**Date:**_____
PROVIDER SIGNATURE

Consent for Release and Use of Photographs and or Video

In connection with the medical services I am receiving from Transformations Medical Spa, I consent that photographs and/ or videos may be taken of me, or parts of my body under the following conditions:

A. The photographs and/or videos may be taken only with the consent of my medical provider, and under such conditions, and at such time as may be approved by her.
B. The photographs and/or videos shall be taken by my medical provider or by a photographer approved by her.
C. My photographs may be utilized by Transformations Medical Spa in the following manner, as long as my identity is not made known:

- Medical records (patient charts)
- Medical research, education or science
- In professional journals, professional videos, or medical books
- On social media tools that include but do not limit to the Transformations website and Facebook page

The undersigned acknowledges that he/she relinquishes all right, title, and interest in these photographs and or videotapes, or any right to profit or gain directly or indirectly realized through the use of the photographs and / or videos.

Name (Print) _____

Patient Signature _____ Date _____

Witnessed: _____