Apex Medical Spa

New Patient Forms

PATIENT INFORMATION

Name: _____ Soc Sec #: _____-_____-_____

Address: _____ City: _____State: _____ Zip: _____

Female: ☐ Male: ☐ Age: _____ DOB: _____ ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Home Phone: _____ Cell Phone: _____ E-mail Address:_____

Employer: _____ Occupation:_____

Emergency Contact Name/Phone#:_____

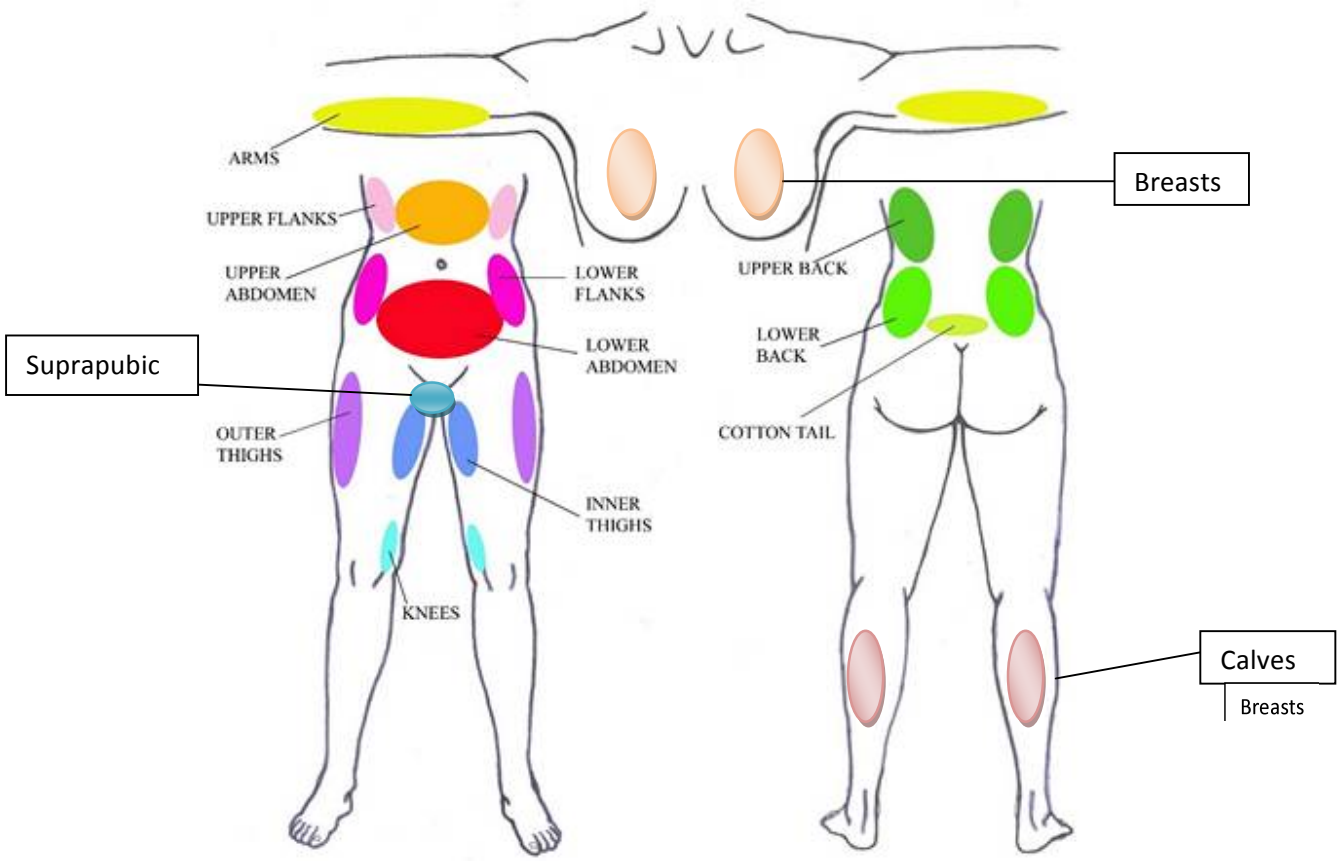
Reason for Consultation Appointment: _____

REFERRED BY:_____

Location of HD Lipo Interested in: ARMS UPPER FLANKS LOWER FLANKS UPPER ABD LOWER ABD

UPPER BACK LOWER BACK CHIN OUTER THIGHS LOWER THIGHS CALVES SUPRAPUBIC

Other Procedure Interested in: _____



Patient Signature: X _____ Date: _____

PATIENT MEDICAL HISTORY

Have you ever had bleeding or clotting problems? _____

Do you take sedatives or related substances? _____

Do you have any known allergies to medications? _____

Do you have any allergies to any other substances? _____

Have you ever had a problem with anesthetics? _____

Do you have a history of Cold Sores/Herpes?_____

Have you recently traveled out of the U.S. or lived in concentrated housing? _____

Have you ever had a T.B. Test, chronic cough greater than three weeks, bloody sputum, unexplained weight loss or night sweats? _____

Do you Smoke? Yes ☐ No ☐ How Long? _____ How Much? _____

Do you drink alcoholic beverages? ☐Yes ☐ No How Long? _____ What? _____

Do you take recreational drugs? ☐ Yes ☐ No How Long? _____ What? _____

HOSPITALIZATION HISTORY

1. _____ **DATE:**_____

2. _____ **DATE:**_____

SURGICAL HISTORY

1. _____ **DATE:**_____

2. _____ **DATE:**_____

CURRENT MEDICATIONS

Please list your medication(*including over the counter and herbal supplements*) you may provide a list to the nurse:

Name/Dose/Quantity	**Name/Dose/Quantity**	**Name/Dose/Quantity**
1. _____/_____/_____	2. _____/_____/_____	3. _____/_____/_____
4. _____/_____/_____	5. _____/_____/_____	6. _____/_____/_____

ALLERGIES

Medication/Reaction	**Food/Reaction**
1. _____/_____	**1.** _____/_____
2. _____/_____	**2.** _____/_____

Patient Signature: X _____ Date: _____

REVIEW OF SYSTEM

Constitutional
- ☐ Chills
- ☐ Fever
- ☐ Weight loss
- ☐ Decline In Health
- ☐ Weakness
- ☐ Fatigue
- ☐ Weight gain

Head
- ☐ Dizziness
- ☐ Headaches
- ☐ Fainting
- ☐ Pain
- ☐ Head injury
- ☐ Sweats

Eyes
- ☐ Blurry Vision
- ☐ Double Vision
- ☐ Eyeglass use
- ☐ Pain with light
- ☐ Unusual Sensations
- ☐ Cataracts
- ☐ Excessive Tearing
- ☐ Coughing
- ☐ Recent Injury
- ☐ Vision Loss

Respiratory
- ☐ Asthma
- ☐ Bronchitis
- ☐ Pleurisy
- ☐ Short of Breath
- ☐ Cough
- ☐ Coughing Blood
- ☐ Positive TB Test
- ☐ Sputum
- ☐ Wheezing
- ☐ Pain
- ☐ Recent Chest X-Ray
- ☐ Tuberculosis

Allergic/Immunologic
- ☐ Coughing
- ☐ Itchy Eyes
- ☐ Runny Nose
- ☐ Watery Eyes
- ☐ Coughing with Exercise
- ☐ Itchy Nose
- ☐ Sneezing
- ☐ Wheezing
- ☐ Hives
- ☐ Recurrent Infections
- ☐ Infections
- ☐ Coughing

Cardiovascular
- ☐ Chest Pain
- ☐ Extremity(s) Cool
- ☐ Heart Murmur
- ☐ History of Heart Attack
- ☐ Rheumatic Fever
- ☐ Short of Breath - Sleeping
- ☐ Ulcers on Legs
- ☐ Palpitations
- ☐ Extremity(s) Discolored
- ☐ Heart Tests (Not EKG)
- ☐ Leg Pain - Walking
- ☐ Short of Breath - Exertion
- ☐ Varicose veins
- ☐ Swelling of Legs
- ☐ High Blood Pressure
- ☐ Recent Electrocardiogram
- ☐ Short of Breath - Lying Flat
- ☐ Thrombophlebitis
- ☐ Diarrhea
- ☐ Liver Disease
- ☐ Antacid use
- ☐ Change in Stool Caliber
- ☐ Decreased Appetite
- ☐ Gallbladder Disease

Gastrointestinal
- ☐ Abdominal Pain
- ☐ Heartburn
- ☐ Rectal Bleeding
- ☐ Black Tarry Stools
- ☐ Change in stool color
- ☐ Excessive Hunger
- ☐ Hemorrhoids
- ☐ Laxative Use
- ☐ Swallowing Problem
- ☐ Constipation
- ☐ Jaundice
- ☐ Abdominal X-Ray Tests
- ☐ Change in frequency of BM
- ☐ Change in stool consistency
- ☐ Excessive Thirst
- ☐ Hepatitis
- ☐ Nausea
- ☐ Vomiting

Musculoskeletal
- ☐ Arthritis
- ☐ Back Problems
- ☐ Muscle Cramps
- ☐ Restricted Motion
- ☐ Joint pain
- ☐ Deformities
- ☐ Muscle Stiffness
- ☐ Weakness
- ☐ Gout
- ☐ Joint Stiffness
- ☐ Paralysis

Other:_____

Patient Signature: X _____ Date: _____

Apex Medical Spa
1701 Bearden Dr Suite 201
Las Vegas NV, 89106

Notice of Financial Responsibility/ Financial Agreement

Private Pay/Self Pay:•

HD Lipo and other cosmetic procedures are non-covered procedure by insurance and thus is not a billable service. We will not bill to your insurance. Full Payment must be made in order to schedule for procedure. All payment must be received at the time of service.

No exceptions.

We accept cash, money orders, cashiers check, credit cards, and debit cards. There will be no refunds or partial refunds.

We request that 24 hrs notice be given to cancel or reschedule an appointment.

We will gladly answer any questions or concerns you may have regarding your financial responsibility as it relates to your care here at Apex Medical Spa.

Please sign below to acknowledge that you have read, understand, and agree to this policy.

Patient Signature: X _____ Date: _____