REJUVENATE
Center for Medical Aesthetics & Wellness
FALGUNI PATEL, MD FACOG

PERSONAL PROFILE AND HEALTH HISTORY

Patient Name:_____Date of Birth:_____

Street Address:_____

City:_____State:_____Zip Code:_____

Preferred Contact Number:_____Marital Status: S M D W

Email:_____Occupation:_____

Primary Care Physician:_____Phone Number:_____

How did you hear about us?

FEMALES

Are you pregnant/breastfeeding?	YES	NO
Are you planning pregnancy?	YES	NO
Do you have regular periods?	YES	NO
Are you going through menopause?	YES	NO

Please list all medications including prescription and over the counter drugs, vitamins, herbs, and supplements:

_____

Are you allergic to any medications, foods or products? If yes, please list below YES NO

_____

MEDICAL HISTORY: *Please check all that apply*

- ☐ Acne
- ☐ Bleeding Disorders
- ☐ Botox
- ☐ Burns/Skin Grafts
- ☐ Cancer
- ☐ Cardiac Conditions
- ☐ Diabetes
- ☐ Eating Disorders
- ☐ Endocrine Disorders
- ☐ Filler Injections
- ☐ Heart Disease
- ☐ Hemorrhoids
- ☐ Herpes Simplex
- ☐ Hepatitis
- ☐ Hernia(s)
- ☐ High Blood Pressure
- ☐ Hirsutism
- ☐ HIV/AIDS
- ☐ Hormone Replacement
- ☐ Implants
- ☐ Kidney Disease
- ☐ Keloid Scars
- ☐ Lupus
- ☐ Liver Disease
- ☐ Metal or other implants
- ☐ Pacemaker
- ☐ Permanent Makeup
- ☐ PCOS
- ☐ Psoriasis/Eczema
- ☐ Radiation/Chemo
- ☐ Rosacea
- ☐ Seizures
- ☐ Skin Cancer
- ☐ Tattoos
- ☐ Thyroid Disease
- ☐ Transplants
- ☐ Other:_____

_____

Please list all cosmetic procedures or surgeries:_____

_____

_____

_____.

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PERSONAL PROFILE AND HEALTH HISTORY

PLEASE ANSWER THE FOLLOWING QUESTIONS

1. Are you currently being treated for any medical conditions? YES NO
   If YES, please explain:_____
   _____
2. Have you ever seen a physician regarding your skin? YES NO
3. Do you have any active skin diseases/infection in the area to be treated? YES NO
4. Do you have any skin allergies? YES NO
5. Have you had skin cancer or pre-cancerous lesions? YES NO
6. Do you have psoriasis/eczema in the area to be treated? YES NO
7. Are there any moles with hair in the area to be treated? YES NO
8. Are you allergic to latex, lidocaine or any lotions? YES NO
9. Have you ever had surgery in the area to be treated? YES NO
10. Have you had any previous laser/other treatments to the area being treated? YES NO
11. Have you/are you using medications such as Acutane? YES NO
    If yes, what is the date of last use?: _____
12. Are you using Retin-A or Tetinoin? YES NO
13. Are you using any skin care products at home? YES NO
    If YES, please list: _____
14. Do you smoke? YES NO
    If YES, please circle: cigarettes / cigars _____/day/week/month
15. Are you currently using/ever used a tanning bed or self-tanner? YES NO
    If YES, when was your last exposure/use?: _____
16. Do you use sunscreen? YES NO
17. Does your skin remain discolored after healing from a cut? YES NO

PLEASE INDICATE WHICH OF THE FOLLOWING CONCERNS YOU HAVE ABOUT YOUR SKIN/BODY?

☐ Acne/Acne Scars	☐ Enlarged Pores	☐ Redness	☐ Stubborn Fat
☐ Age Spots	☐ Hair Removal	☐ Rosacea	☐ Sun Damage
☐ Aged Skin	☐ Melasma	☐ Scars	☐ Texture
☐ Double Chin	☐ Oily Skin	☐ Skin Laxity	☐ Uneven Skin Color
☐ Dry/Sensitive Skin	☐ Pigment Changes	☐ Spider Veins	☐ Wrinkles

PLEASE INDICATE THE SERVICE(S) YOU ARE INTERESTED IN OR WOULD LIKE MORE INFORMATION ON:

☐ Acne Treatment	☐ Laser Vein Treatment	☐ Pigment Treatment	☐ Sun Damage Repair
☐ Age Spot Treatment	☐ Laser Hair Removal	☐ Scar Treatment	☐ Vaginal Rejuvenation
☐ Botox	☐ Melasma	☐ Skin Rejuvenation	☐ Weight Loss
☐ Fillers		☐ Skin Resurfacing	

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POLICIES

Thank you for taking the time to complete our Patient Intake form. With the following information we will be better able to serve you. Our goal is provide you with excellent service and results. At future visits, please let us know if any of your information changes. All information and treatments are confidential.

Cancellation Policy

We understand that there are times when you must cancel or reschedule an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule you for a visit, due to a seemingly full appointment book. If an appointment is not cancelled at least 24 hours in advance you will be charged a $50 fee. Each patient must leave a credit card on file to be charged in such instance.

Card Number:_____Exp:_____CCV:_____Zip Code:_____

I understand that results ARE NOT guaranteed. There are many variables that are beyond our control that affect the procedure outcomes, especially individual expectations. We maintain our equipment and continue staff education and training regarding technique. There are times when the human body does not respond as well as we would like. Lifestyle choices, diet, exercise, hydration, prior skin damage, sun exposure and many other factors (i.e. medication use and medical/social history) affect the final results. All of our patients are unique and have unique needs and expectations. Please discuss your treatment expectations with Dr. Patel prior to your treatment because ***there are no refunds.*** If you are paying by credit card, *please* make sure you give the correct card at check out; once a card is charged ***we cannot reverse the transaction.***

For the purpose of documentation, I also consent to "before and after" photographs which may_____ or may not_____ be used in advertising. (check one)

I confirm that the answers I provided are true and correct. I authorized Dr. Falguni Patel and Rejuvenate Center for Medical Aesthetics to charge my credit card on file for any no show or cancelled appointments that occur within 24 hours. I understand all of the above mentioned policies pertaining to the office of Dr. Falguni Patel and Rejuvenate Center for Medical Aesthetics.

Patient Name: _____ DOB: _____

Patient Signature: _____ Date: _____

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PATIENT RESPONSIBILITY FOR FOLLOW-UP CARE PLEDGE

I, _____ (print full name), hereby acknowledge and understand that even with the best training, skill and experience, a medically trained professional is not always capable of solving my medical problems/aesthetic concerns. Therefore, I understand it is important that any and all recommendations by Dr. Patel are followed completely in order to increase the likelihood of a positive and healthy treatment/outcome. I acknowledge and understand that if Dr. Patel prescribes any medication to me that the proper taking of any such medicine shall be my sole responsibility (or my guardian who has attended this consultation). I agree to properly follow the prescribed dosage and frequency amounts of these medicines as recommended by Dr. Falguni Patel, and follow up with an office visit if required.

I understand that if Dr. Patel refers me to see another doctor or receive another treatment, such as cream(s) and/or oral supplement(s), this timely recommendation is important and essential to the ultimate success of my treatment/outcome. *I understand that it is NOT possible for any person in this office to constantly follow-up to ensure that I have followed these recommendations*. Therefore, I understand that if I fail to see the recommended specialist or obtain the test for which I was referred immediately, this may risk my current health or increase future health risks.

I understand that it is solely MY responsibility to follow any of the medical advice given by any medical person in this office and any bad health outcome from my failure to follow the advice of my doctors should be expected.

Patient Signature:_____ Date: _____

Witness/Staff Signature: _____ Date:_____

Physician Signature: _____ Date: _____

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PATIENT FINANCIAL POLICY & AGREEMENT

PROCEDURE/SURGERY DEPOSIT

Should the patient choose to proceed with a procedure/surgery, a 20% OR $500 (whichever is greater) NON-REFUNDABLE deposit is required to reserve your procedure/surgery date. This deposit is credited towards the balance due, as illustrated in the price quotation of your requested procedure(s). ***Cancellation of your reserved procedure/surgical date regardless of the notice given will result in the forfeiture of the 20% NON REFUNDABLE deposit.***

CANCELLATION/NO SHOW/REFUND POLICY

Upon giving a procedural/surgical deposit, you understand that a date has been reserved *specifically for you,* the patient. This involves the commitment of your surgeon, anesthesiologist (if applicable), surgery and recovery room team (if applicable), and necessary procedure/surgery tools/equipment and supplies to be reserved for the time period required to perform your procedure on the date you (the patient) have chosen to reserve.

As such, you (the patient) acknowledge that any cancellation of the reserved procedure/surgery date less than 7 days prior to scheduled date, is an insufficient period of time within which Rejuvenate Center for Medical Aesthetics & Wellness can reschedule or schedule another patient to fill the cancelled time slot. *Therefore, any cancellation or postponement initiated by the patient with less than 7 days notice prior to the scheduled procedure/surgery date will result in you (the patient) forfeiting all fees, including the 20% deposit.*

If you are more than 30 minutes late to your scheduled/confirmed surgical start time and you did not give the office a courtesy call, you will be considered a NO CALL/NO SHOW and you will forfeit the entire amount of the surgery cost that has been paid in advance. You may reschedule the procedure should you choose but please be advised that you will be required to pay for the surgery again in its entirety.

Any refunds allotted by Rejuvenate Center for Medical Aesthetics and Wellness will require a 15% transaction fee if payment was made via credit card.

PAYMENT SCHEDULE

After Rejuvenate Center for Medical Aesthetics & Wellness has received your deposit, all balances due for the procedure must be PAID IN FULL no later than ONE WEEK prior to your scheduled procedure/surgery date. You will be required to have a pre-procedure visit one week prior to your surgery so final payment will be made no later than this visit.

ACCEPTABLE METHODS OF PAYMENT

We accept Cash, Checks, CareCredit and All Major Credit Cards.

I HAVE READ AND UNDERSTAND THE OUTLINED PATIENT FINANCIAL AGREEMENT PROVIDED BY REJUVENATE CENTER FOR MEDICAL AESTHETICS AND WELLNESS.

PROCEDURE/SURGERY DETAILS:

PROCEDURE/SURGERY DATE/TYPE: _____/_____

PRESCRIPTION(S) GIVEN: Y / N / N/A

Patient Name: _____ D.O.B: _____

Patient Signature: _____ Date: _____

Witness/Staff Signature: _____ Date: _____

PROCEDURE/SURGERY PRICE QUOTED: $_____ DEPOSIT AMOUNT: $_____

BALANCE REMAINING: $_____ DUE BY: _____