Rejuv Cosmetic Center

59 Mine Brook Road, Bernardsville, NJ 07824
Phone: (908) 630-0007

Please provide the following information as accurately as possible.

Patient Name: _____ Date: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Email Address: _____

Sex: M/ F Age: _____ Birth Date: _____ Marital Status: Single/ Married/ Divorced/ Widowed

Patient Employer: _____ Occupation: _____

Phone: _____

Pharmacy Name: _____ Location: _____

Phone: _____

Referred By: Facebook/ Instagram/ Google/ Email/ Friend/ Employee

Friend or Employee's Name: _____ Email Address: _____

Emergency Contact's Name: _____

Relationship: _____ Phone: _____

Medical History

Date: _____

Patient Name: _____ Age: _____ Height: _____ Weight: _____LBS

Medical Illness: _____
_____

Past Surgical History/ Hospitalizations: _____
_____

(Please include: Appendectomy, Tonsillectomy, Cataract, C-Section, Hernia, Gall Bladder, Hysterectomy, etc.)

Allergies: _____
_____

Are you allergic to LATEX? YES/ NO

Medications & Dosage: _____
_____

1. Do you take aspirin? YES/ NO If, yes have you taken it in the last week? _____ How much/ often? _____
2. Do you have any bleeding tendencies? YES/ NO
3. Have you taken any cortisone or steroids in the past 6 months? YES/ NO
4. Do you have a cold? YES/ NO Do you have a cough? YES/ NO
5. Do you have asthma? YES/ NO
6. Have you had difficulty breathing? YES/ NO
7. Do you smoke? YES/ NO
8. Have you ever had a heart attack? YES/ NO
9. Have you ever had angina or pain in your chest? YES/ NO
10. Could you be pregnant? YES/ NO
11. Are you breastfeeding? YES/ NO
12. Do you drink more than 2 alcoholic drinks per day? YES/ NO
13. Have you ever had Hepatitis? YES/ NO
14. Are you being treated for high blood pressure? YES/ NO
15. Do you have Epilepsy, seizures or fainting spells? YES/ NO
16. Do you keloid or scar badly? YES/ NO
17. Are you currently under the care of a psychiatrist? YES/ NO
18. Are you currently using Retin A or Tretinoin? YES/ NO
19. Are you currently taking Accutane? YES/ NO
20. Are you currently taking immunosuppressants? YES/ NO
21. How much water do you drink per day? _____ glasses
22. Do you exercise or participate in any sports? YES/ NO
23. Have you ever received a facial? YES/ NO
24. Do you have a history of Herpes (cold sores)? YES/ NO
25. Have you ever received a massage? YES/ NO Type preferred: Deep/ Medium/ Light Pressure

**Facial and Massage Clients: On the day of your visit, if you have any of the following symptoms present please inform the staff. Sunburn, Inflammation, Severe Pain, Headache, High or Low Blood Pressure, Thyroid Condition, Irritated Skin, Poison Ivy, Open Cuts, Bruises or Burns.

Print Name: _____ Date: _____

Signature: _____

Signature of Responsible Party: _____ Date: _____

Relationship to Patient: _____

Consent To Use and Disclose Patient Health Information

In general, The HIPPA privacy rule gives the right to request a restriction on uses and disclosures of their protected health information (PHI).

The undersigned consent is to the use or disclosure of my (or patient's if the undersigned is the patient's personal representative) individually identifiable health information by Rejuv Cosmetic Center, LLC and its physician(s) and staff. As outlined by Federal Law, for the purposes set forth below:

1. To provide the patient with medical treatment and related services, including coordination or management of patient care with a third party that is also involved in patient's treatment, such as your primary care physician, a specialist, or a laboratory to which we refer the patient for further care.

2. As necessary to run our business operations and to support the core functions of treatment and payment, including without limitations, quality assessment and improvement activities, employee evaluation activities, conducting medical reviews, legal auditing services, business planning and development activities, and business management and general administrative activities.

3. As required or permitted by applicable state and/ or Federal Law as described at greater length in the "Notice of Privacy Practices" provided to you along with this acknowledgement of privacy policy.

Further, in order to facilitate and expedite my care, my signature below authorizes Rejuv Cosmetic Center, LLC to have access to and obtain copies of my prior, current and future medical records (physician, hospital, laboratory, etc.) for the purpose of treatment and payment in accordance with the HIPPA regulation. In addition, my signature below confirms that I have received the complete " Notice of Privacy Practices". This authorization will remain valid until my written revocation.

Print Name: _____ Date: _____

Signature: _____

Signature of Responsible Party: _____ Date: _____

Relationship to Patient: _____

1. Patient received Notice of Privacy Practices. _____ Initials

2. Patient agrees to have messages left on his/her home answering machine, voicemail or cell phone voicemail regarding appointments and lab results. _____ Initials

3. Patient agrees to receive appointment reminders and lab results by mailto the address listed in the medical record. _____ Initials

4. Patient understands that they may list alternative methods of receiving health information example: Email, other addresses or Phone numbers. _____ Initials

5. Patient authorizes the release of his/her health information to the following person(s).
   Name: _____ Phone: _____
   Relationship to patient: _____ _____ Initials

I have read the above policies and agree to its terms.

Print Name: _____ Date: _____

Signature: _____

Signature of Responsible Party: _____ Date: _____

Relationship to Patient: _____