Mill Plain Medical Aesthetics

103 Mill Plain Rd Suite #2
Danbury, CT 06811

PATIENT INTAKE FORMS

Dear Patient,

Thank you for contacting us at Mill Plain Medical Aesthetics and for scheduling an appointment with us. You can feel confident that our staff is committed to meeting your needs.

Mill Plain Medical Aesthetics, we strive to provide the most current, safe and effective procedures available today. By combining procedures that have stood the test of time with newly proven advances in technology, our office is on the cutting edge and able to provide you with the best options available.

In order to minimize your wait time, please complete the enclosed New Patient forms prior to your visit and email them before your appointment. In the meantime, if you have any questions at all, please feel free to call our office. The entire office is dedicated to giving you the best experience available.

If for any reason you are unable to keep your appointment, please contact us within 24 hours of your scheduled appointment to cancel or reschedule. We understand that some delays are unavoidable but please be aware that if you are 30 minutes late (or later), we will do our best to fit you in but you may have to wait or reschedule.

Thank you for choosing Mill Plain Medical Aesthetics

CONTACT US
203 456-3906

Website

www.millplainmedaesthetics.com

email: info@millplainmedaesthetics.com

Mill Plain Medical Aesthetics

Date:____/____/____

Name: [First]_______________________[M.I.]______[Last] ______________________________

Address:____[Apt.] ___________ Age: __________ D.O.B:____/____/____

City:__________________________________State:______Zip:______________

Home phone: _____________________________ Cell phone: __________________________

Work phone: _____________________________

Marital Status: ☐ Single | ☐ Married | ☐ Other E-mail: ____

EMPLOYMENT INFORMATION

☐ Full Time | ☐ Part Time | ☐ Student | ☐ Retired | ☐ Other Occupation: ___________________________

Employer/School:____ Work phone: _________________________

Work/School Address:_______________________________City:________________________State:_______Zip: _________

EMERGENCY CONTACT

Name: [First] _______________________ [Last] _________________________ Cell phone: _____________________

Relationship to Patient: ____ Work phone:______________________

REFERRAL INFORMATION

Referring Physician or Patient: ____

How did you hear about Mill Plain Medical Aesthetics? ____

Have you been to our website? ☐ Yes | ☐ No

If yes, was our website helpful? ☐ Yes | ☐ No

PROCEDURE INFORMATION

What is the reason for your visit today? *[Check all applicable procedures below]*

- ☐ Botox/Dysport/Xeomin
- ☐ Facial Fillers (Radiesse, Juvederm, Restylane, Voluma, Belotero
- ☐ Liquid Facelift
- ☐ Hyperhidrosis
- ☐ Hand rejuvenation
- ☐ Skin care
- ☐ Acne treatment
- ☐ Microneedling
- ☐ Facials
- ☐ Chemical Peel
- ☐ Herbal Peel
- ☐ Cellulite treatment
- ☐ Sculptra
- ☐ Thinning hair
- ☐ PRP (Platelet Rich Plasma)
- ☐ Other: ____________________ ______________________________

Have you consulted and/or had any procedure(s) indicated above? ☐ Yes | ☐ No

PREVIOUS AESTHETIC PROCEDURES

Do you currently get/use: □ Facials / Peel □ Waxed □ Electrolysis □ Depilatories □ Microdermabrasion

Have you ever had laser resurfacing? Y / N

Have you had collagen/dermal filler injection(s)? Y / N

Have you had a Botox injection(s)? Y / N

Have you recently had facial or cosmetic surgery? Y / N

ALLERGIES

Are you allergic/sensitive to? ("X" all that apply)

☐ Lidocane □ Adhesives □ Latex □ Aspirin □ Perfumes □ Milk □ Eggs □ Hydroquinone

☐ Mushrooms □ Apples □ Grapes □ Citrus □ Aloe Vera □ Shellfish: ____________________

☐ Other: ____________________

List other allergies to any medication: ____________________

Have you ever used any products that caused a bad reaction? Y / N

If yes, describe: ____________________

Have you ever had a skin allergy or sensitivity? (Rash, irritation, peeling, swelling, hives, etc.)? Y / N

If yes, describe: ____________________

PERSONAL HEALTH HISTORY

Have you ever had or have been treated for: *[Check box for those that apply]*

☐ Heart trouble
☐ Heart Disease
☐ Bleeding Problems
☐ HIV or AIDS
☐ Asthma/wheezing
☐ Allergy/Hay fever

☐ Stomach Problems
☐ Gastric Reflux
☐ Kidney Disease
☐ Neuritis (nerve inflammation)
☐ Bell's Palsy
☐ Drug or alcohol addiction

☐ Herpes
☐ Autoimmune Diseases: Scleraderma, Lupus, Sjögren's, MS, Rheumatoid Arthritis, Vitiligo Psoriasis, Alopecia Areata
☐ Other: ____________________

Do you have a family history of any medical problems?
Please list Family member(s) and medical conditions: ____________________

____

Please list prior Surgical procedures: ____________________

____

Please list ALL medications and/or dietary supplements including:
(Prescriptions, Over the Counter Medicines, Aspirin, Vitamins and Herbal Supplements such as Fish Oil, Saw Palmetto, Flax Seed Oil and St. John's Wort)

____

Have you ever smoked tobacco products? Y / N

If Yes, # of packs per day: ____________________ # of years: ____________

REVIEW OF SYSTEMS

Please answer the following Yes or No questions to the best of your ability. Do you have or had any of the following conditions, illnesses or symptoms?

CARDIOVASCULAR

High Blood Pressure	☐ Yes | ☐ No
Heart Attack	☐ Yes | ☐ No
Angina/chest pain	☐ Yes | ☐ No
Heart bypass surgery	☐ Yes | ☐ No
Pacemaker	☐ Yes | ☐ No
Heart Failure	☐ Yes | ☐ No
Irregular Heartbeat	☐ Yes | ☐ No
Heart Murmur	☐ Yes | ☐ No

Comments:________________________________

RESPIRATORY

Abnormal Chest X-ray	☐ Yes | ☐ No
Asthma	☐ Yes | ☐ No
Bronchitis	☐ Yes | ☐ No
Emphysema	☐ Yes | ☐ No
Recent Chest Infection	☐ Yes | ☐ No
Shortness of Breath	☐ Yes | ☐ No
Shortness of Breath at night	☐ Yes | ☐ No
Shortness of Breath on exertion	☐ Yes | ☐ No
Cough	☐ Yes | ☐ No
Cough with Sputum	☐ Yes | ☐ No
Sleep Apnea	☐ Yes | ☐ No
Use a C-PAP Machine	☐ Yes | ☐ No

GASTROINTESTINAL

Jaundice	☐ Yes | ☐ No
Gallstone	☐ Yes | ☐ No
Liver Disease (Cirrhosis)	☐ Yes | ☐ No
Hepatitis	☐ Yes | ☐ No
Ulcers	☐ Yes | ☐ No
Hiatal Hernia	☐ Yes | ☐ No
Heartburn	☐ Yes | ☐ No

SKIN

Cancer	☐ Yes | ☐ No
Radiation	☐ Yes | ☐ No
Atypical Skin Lesions	☐ Yes | ☐ No

ENDOCRINE

Diabetes	☐ Yes | ☐ No
Hyperthyroidism	☐ Yes | ☐ No
Hypothyroidism	☐ Yes | ☐ No
Hypoglycemia	☐ Yes | ☐ No
High Cholesterol	☐ Yes | ☐ No

PSYCHIATRIC

Depression	☐ Yes | ☐ No
Anxiety	☐ Yes | ☐ No
Psychiatric Care	☐ Yes | ☐ No
Obsessive Compulsive Disorder	☐ Yes | ☐ No

NEUROLOGICAL

Stroke	☐ Yes | ☐ No
Seizures	☐ Yes | ☐ No
Fainting	☐ Yes | ☐ No
Dizziness	☐ Yes | ☐ No
Headache	☐ Yes | ☐ No
Sciatica	☐ Yes | ☐ No
Herniated disc	☐ Yes | ☐ No
Arthritis	☐ Yes | ☐ No
Rheumatoid	☐ Yes | ☐ No

HEMATOLOGIC/ONCOLOGIC

Bleeding Tendency	☐ Yes | ☐ No
Easy Bruising	☐ Yes | ☐ No
Anemia	☐ Yes | ☐ No
Sickle Cell Disease	☐ Yes | ☐ No
Blood clots in legs	☐ Yes | ☐ No
Blood clots in lungs	☐ Yes | ☐ No
Radiation Therapy	☐ Yes | ☐ No

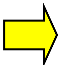
EYES

Cataracts	☐ Yes | ☐ No
Glaucoma	☐ Yes | ☐ No
Dry Eyes	☐ Yes | ☐ No
Do you wear Contact Lenses?	☐ Yes | ☐ No

Please list any other medical conditions that are not listed above: ____

____

This is a confidential report of your medical history and will be kept in this office. Information contained herein will not be released to any person or organizations except when you have authorized us to do so.



______________________________ ______________________________ ____/____/____

Patient Signature ***[if other than patient state relationship]*** ***Date***

ACKNOWLEDGEMENT OF PRIVACY PRACTICES

At Mill Plain Medical Aesthetics, PC your privacy is a very important part of our mission and plays a very big factor in your experience. Mill Plain Medical Aesthetics, PC and staff adhere to the highest standards of respecting and protecting patient privacy and the confidentiality of your health care information. Additionally the team complies with all state and federal regulations regarding the privacy of individual health care information, including HIPPA (Health Care Insurance Privacy and Protection Act), enacted on April 14, 2003.
As of April 14th 2003, we are required by law to offer you a copy of the “Notice of Privacy Practices” regarding your Personal Health Information (PHI).

Your PHI, also known as your health or medical record, serves as a:

- Basis for planning your care and treatment
- Means of communication among the many health professionals who contribute to your care
- Legal document describing the care you received
- Means by which you or a third---party payer can verify that services billed were actually provided
- A tool in educating health professionals
- A source of data for medical research
- A source of information for public health officials charged with improving the health of this state and the nation
- A tool with which we can assess and continually work to improve the care we render and the outcomes we achieve

The “Notice of Privacy Practices” details the following:

- How we may use/disclose your PHI to carry out treatment, payment or health care operations.
- How you may request copies of your healthcare information.
- How you may verify the accuracy of this information.
- How you may request an accounting of certain external disclosures of your PHI.

I understand that as part of this organization’s treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax.

Please acknowledge that you received a “Notice of Privacy Practices” by signing below:

“I have received a Notice of Privacy Practices by the office of Mill Plain Medical Aesthetics, PC and I fully understand and accept the terms of this consent.”

Signature: (Patient, Parent or Guardian) ____ Date: _____/_____/____