PATIENT REGISTRATION FORM

OFFICE USE: N.O.D. __________ Q.B. __________ P.P. #: ______________________

Health Card #: __ __ __ __-__ __ __- __ __ __ Version Code: __ __ Expiry Date _____/_____/_______
DD/MM/YYYY

Last Name: ___________________________ First Name: ____

Birthday (day) _______ (month) __________ (year) _________________________ Sex: M_____F______

Street Address: ____ Apt #: ______________

City: _____________________________ Prov: _____________ Postal Code: _________________________

Home Phone #: ____________________________ Cell Phone #: ___________________________________

Email Address: ____

Occupation: _______________________________________ Business #: ________________________________

<u>We may be contacting you post treatment to follow up</u>. Please indicate which method you prefer.

KINDLY CHECK ALL THAT APPLY: Home ☐ Business☐ Cell ☐ Email ☐

May we contact you about new services or specials via Email? ____ Yes ____ No
*****THE ONLY WAY WE CAN NOTIFY YOU OF OUR PROMOTIONS IS THROUGH EMAIL.*****

How did you hear about our clinic?

Referred By: ☐ ____

Google/Internet ☐ Radio ☐ TV ☐ Facebook ☐ Instgram ☐ YouTube ☐ Website ☐

What keywords did you use to search online? ____

Initial _______ **I UNDERSTAND THERE IS A $150 NON-REFUNDABLE FEE FOR ANY MISSED PROCEDURAL APPOINTMENT WITH DR. MATTA UNLESS THERE IS A 24 HOUR NOTICE.**

Please Print Full Name Legibly	Patient Signature	Today's Date: DD/MM/YYYY	Dr. Matta

MEDICAL HISTORY: *please answer all questions below (more space available on Page 3)*

Are you currently taking any medications? Yes ☐ No ☐ List all **MEDICATIONS** you are currently taking, including Herbals, Vitamins or alternatives including Hormones, Birth Control Pills and dosage.	**HOSPITALIZED** or **SURGERIES?** Yes ☐ No ☐ Including C-Sections. If yes, for what reason?
Do you have **ALLERGIES** or **SENSITIVITIES** to Medications, Medical products (ie: adhesives or latex), Soy, Anesthetics (i.e. dental freezing), Food or anything else? Yes ☐ No ☐No If so, please list:	Have you had any COSMETIC procedures in the past? (i.e. Botox, Fillers, Laser, etc). Yes ☐ No ☐ If so, please list:
Are you pregnant? Yes ☐ No ☐ N/A ☐ Trying to become pregnant? Yes ☐ No ☐ N/A ☐ Are you breastfeeding Yes ☐ No ☐ N/A ☐	Did you have any adverse reactions to the above?
Do you take **BLOOD THINNERS** such as Coumadin, Plavix, Aspirin, Advil or Red Wine? Yes ☐ No ☐ If yes, what was taken and when was the last time?	Do you Smoke? Yes ☐ No ☐ If yes, how much and for how long? ___________________________ Did you ever smoke? Yes ☐ No ☐ If yes, when did you quit? ___________________________________
Do you have any **INFLAMMATORY CONDITIONS**: Rheumatoid Arthritis Yes ☐ No ☐ Lupus Yes ☐ No ☐ Autoimmune Diseases Yes ☐ No ☐ Please specify:	Do you suffer from: Depression? Yes ☐ No ☐ Anxiety? Yes ☐ No ☐ Any Psychological Disorders? Yes ☐ No ☐ Please specify:
Have you ever had a stroke? Yes ☐ No ☐ Have you ever had a mini-stroke? Yes ☐ No ☐	Do you bleed easily? Yes ☐ No ☐
Have you ever had cancer? Type? Yes ☐ No ☐	Do you get keloids? Yes ☐ No ☐ Abnormal scars? Yes ☐ No ☐
Have you experienced blood clots in the legs or lungs? Yes ☐ No ☐	Do you have any eye conditions? Yes ☐ No ☐ Glaucoma? Yes ☐ No ☐
Do you have "low blood" or anemia? Yes ☐ No ☐	Do you have diabetes? Yes ☐ No ☐ What type? I ☐ or II ☐
Do you experience chest pain? Yes ☐ No ☐ Do you experience angina? Yes ☐ No ☐	Do you have any kidney problems? Yes ☐ No ☐
Do you get shortness of breath when lying flat? Yes ☐ No ☐	Do you have a liver disease Yes ☐ No ☐ Jaundice? Yes ☐ No ☐
Do you have any lung condition? Yes ☐ No ☐ Do you have asthma? Yes ☐ No ☐	Have you ever used Addictive Drugs? Yes ☐ No ☐ Suffered from Alcohol Abuse? Yes ☐ No ☐
Do you have a fast heartbeat? Yes ☐ No ☐ Do you have an irregular heart beat? Yes ☐ No ☐	Do you have high cholesterol? Yes ☐ No ☐

Please Print Full Name Legibly ______ Patient Signature ______ Today's Date: DD/MM/YYYY ______ Dr. Matta ______

MEDICAL HISTORY cont'd: *please answer all questions below*

Do you have heart problems? Yes ☐ No ☐	Have you ever had an organ transplant? Yes ☐ No ☐
Have you had tuberculosis? Yes ☐ No ☐	Do you have bladder/incontinence problems? Yes ☐ No ☐
Do you get cold sores? Yes ☐ No ☐	Have you ever had an irregular pap? Yes ☐ No ☐
Are you hard of hearing? Yes ☐ No ☐ Do you use a hearing aid? Yes ☐ No ☐	Do you have any **NEUROLOGICAL DISORDERS**? Yes ☐ No ☐ Multiple Sclerosis? Yes ☐ No ☐ Myasthenia Gravis? Yes ☐ No ☐
Do you have a pacemaker? Yes ☐ No ☐ Do you have a metal implant? Yes ☐ No ☐	Do you have epilepsy? Yes ☐ No ☐ Seizures? Yes ☐ No ☐ Sometimes faint? Yes ☐ No ☐
Do you get confused? Yes ☐ No ☐ Do you suffer from memory loss? Yes ☐ No ☐	Do you have Hepatitis B? Yes ☐ No ☐ Hepatitis C? Yes ☐ No ☐ HIV? Yes ☐ No ☐
Have you recently had any unexplained weight loss? Yes ☐ No ☐ If yes, when did it start? ___________________________________	

Please give details about any medical item that you checked "yes" or any other comments

Would you like us to teach you about skin care & health? ____ Yes ____ No

What skin care products are you currently using? ____

PLEASE INDICATE ANY CONCERNS YOU WOULD BE INTERESTED ADDRESSING:

☐ Acne / Acne or Facial Scars	☐ Aging Face, Neck, Hands/Sun Spots	☐ Botox Cosmetic®
☐ Cellulite	☐ Deflated Cheeks	☐ Dry/itchy/flaky skin
☐ Enhancing and Defining Lips	☐ Excessive Sweating -	☐ Facial veins / Redness
☐ Fillers	☐ Hair Removal	☐ Hyper/Hypo Pigmentation
☐ Large Pores	☐ Leg Veins	☐ Longer Eyelashes
☐ Migraines / Headaches	☐ Pain	☐ Puffy eyes and dark circles
☐ Sagging Skin	☐ Scars	☐ Skin Care Products
☐ Skin Resurfacing	☐ Skin Tags / Moles	☐ Smoker's Lines
☐ Spider Veins	☐ Stretch Marks	☐ Thinning Hair
☐ Urinary Incontinence	☐ Vaginal Dryness	☐ Wrinkles

Any other concerns you would like addressed:

______________________________	______________________________	______________	______________
Please Print Full Name Legibly	Patient Signature	Today's Date: DD/MM/YYYY	Dr. Matta