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Cosmetic Services - Injectables Patient Registration

Legal Name: _____ Preferred Name: _____
Last First Middle

Social Security Number: _____ Sex: Female Male

Date of Birth: _____ Age: _____ Race: _____

Marital Status: Single Married Partnered Divorced Separated Widowed Other

Address: _____

City/State/Zip: _____

Home Phone: () _____ Work Phone: () _____ Cell: () _____

E-mail: _____

Employer: _____ Occupation: _____

Full Time Part Time Self Employed Homemaker Student Disabled Unemployed

How did you hear about us? _____

EMERGENCY INFORMATION

In case of an emergency, we would appreciate the name of a contact.

Name: _____ Relationship: _____

Home Phone: () _____ Work Phone: () _____
Last First Middle

Please read the following statement carefully before signing:

I authorize treatment of the person named above and agree to pay all fees for such treatment. I have been informed of the \$35.00 fee (per RCW 62A.3-515 & 520) on checks returned from my bank for insufficient funds. The undersigned agrees that whether s/he signs as an agent, that s/he is obligated to pay for the account. Should the balance of the account exceed an amount the undersigned agrees to pay in full, a payment plan can be established with 1% per month interest (per RCW 19.52) on the unpaid balance.

Signature: _____ Date: _____

Medical History

Date: _____

Name: _____

DOB: _____ Age: _____

PAST MEDICAL HISTORY

Please circle the appropriate response:

Are you currently under medical care for any reason?	YES	NO	Past or present use of tobacco? Current use: _____ If quit, when? _____	YES	NO
Problems with anesthesia?	YES	NO	Past or present use of alcohol? Current use. How often? _____ If quit, when? _____	YES	NO

PAST COSMETIC TREATMENTS

Have you had prior treatment with Botox (botulism toxin) or dermal fillers? YES NO

If so, when and what areas were treated? _____

On a scale of 1 - 10, 10 being very satisfied, rate your results with these treatments: _____

Did you have problems with the treatment? YES NO

If so, please explain: _____

PAST SURGICAL HISTORY		PAST HOSPITALIZATIONS	
Please list all surgeries (include cosmetic procedures)	Approximate date	Please list all hospitalizations	Approximate date

It is the responsibility of our patients to accurately inform us of any medications, medical history or information possibly relevant to your surgery. Any misinformation, purposeful or otherwise may lead to improper treatment and potentially adverse reactions to proposed medications. Any purposeful misinformation related to the information presented in this record may result in termination of the doctor patient relationship and any care with our organization.

FOR OFFICE USE ONLY - PATIENT MEDICAL SUMMARY

Review of Symptoms

Please circle the appropriate response

GENERAL MEDICAL HISTORY					
Sun/tanning exposure within last month	YES	NO	HIV	YES	NO
Any anesthesia problems	YES	NO	AIDS contact	YES	NO
Weight stable for 6 months	YES	NO	TB exposure or the disease	YES	NO
Weight loss or gain	YES	NO	Swollen glands	YES	NO
			Recurring infections	YES	NO
Keloids	YES	NO	Skin infections	YES	NO
Abnormal pigmentation	YES	NO			
Cold sores	YES	NO	Rectal bleeding	YES	NO
Sun hypersensitivity	YES	NO	Liver disease	YES	NO
Rash	YES	NO	Hepatitis or cirrhosis	YES	NO
Acne	YES	NO			
Skin cancer	YES	NO	Diabetes currently?	YES	NO
Chemical peels	YES	NO	Age of onset: _____		
Lupus	YES	NO	Diabetes control	GOOD	POOR
Excessive sweating	YES	NO	Excessive thirst	YES	NO
Difficulty with speech	YES	NO	Bleeding problems	YES	NO
Neuromuscular disorders	YES	NO	Blood clots in legs or lungs	YES	NO
Myasthenia gravis	YES	NO	Anemia	YES	NO
Currently pregnant?	YES	NO			

MEDICATIONS

List all daily medications including over-the-counter medications and vitamins, herbs or supplements, and contraceptives. Please include dosage, frequency, and purpose if known.

MEDICATION	DOSAGE	FREQUENCY	PURPOSE

Aspirin	YES	NO	NSAIDS	YES	NO
ibuprofen	YES	NO	Insulin	YES	NO
Aleve	YES	NO	Steroids	YES	NO

ALLERGIES

	To what?	What kind of reaction?
Medications:		
Other allergies:		

Sensitive/allergic to:	Latex	YES	NO	Iodine	YES	NO
	Dye	YES	NO	Tape	YES	NO

SOCIAL HISTORY

Education: _____

What type of work or hobbies do you do? _____
