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Patient Intake Form

Patient Information

Name: _____ Date: _____/_____/_____ (yyyy/mm/dd)

PHN: _____ Age: _____

Address: _____

Phone #: _____ Occupation: _____

DOB: _____/_____/_____ (yyyy/mm/dd)

Past Medical History (List all medical conditions and procedures, surgical / cosmetic / injection)

_____

_____

_____

_____

_____

_____

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_____

_____

List all current medications

_____

_____

_____

_____

Allergies

_____

_____

Are you pregnant / breastfeeding / planning pregnancy? ☐ Yes ☐ No

We require at least 24 hours advance notice if you are unable to keep your scheduled appointment. If you fail to notify us 24 hours in advance you will bee billed a set fee. This fee is your responsibility to pay and is not considered a reimbursable charge by your private insurance company. All our services will be subject to this policy for late cancelled and no-show appointments.

Name (Please Print) Signature Date