The Aesthetic & Wellness Center
Restoring your health and beauty
941-749-0741 - www.tawcenter.com
3825 State Road 64 East Ste. 300, Bradenton, FL 34208

PATIENT INFORMATION FORM

Name: (Last) _____ (First) _____ (M.I.) _____Sex: (M / F)
SSN: _____ Birth Date: _____ Age: _____
Home Address: _____
City: _____ State: _____ Zip Code: _____
Home Phone: ( ) _____ Cell Phone: ( ) _____
Best number to reach you: _____

Would you like to receive?
Email appointment reminders: _____Yes _____ No
E-Newsletter & Promotions: _____Yes _____ No
Email: _____

Employment Information:
Employer: _____ Occupation:_____
Phone: ( ) _____ ext: _____
In Case of Emergency:
Name: _____ Relationship: _____ Phone :( )_____

How did you hear about us?

- □ Magazine
- □ Physician Office
- □ Newsletter
- □ Referral by Current Patient
- □ Sign/Location
- □ Seminar
- □ Coupon Book
- □ Gyms
- □ Local Salon/Spa
- □ Radio advertising
- □ Television
- □ Internet Promotion
- □ Facebook
- □ Website
- □ Internet search

Financial Policy:
Please be advised that full payment for all services will be due at the time services are rendered. For your convenience we accept Visa, Master Card, Discover, Debit Card or Cash. We DO NOT accept personal checks.

No Show or Cancelled Appointment Policy:
We do not accept clients without appointments. Appointments that are not cancelled 24 hours prior to appointment time will be billed a $25.00 cancellation fee. Cancellation or no-show fees must be paid prior to making future appointments and are the sole responsibility of the client. Missed appointments cannot be credited to next week's treatment period. Lipotropic injections missed cannot be credited for future injections. If you are enrolled in a special program through your employer, cancelled or no show appointments will be applied to your treatment plan and will be charged to your treatment program. Repeat cancelled, or no-show appointments may result in termination from treatment at this practice.

Cancellation Policy
If you purchase a treatment package and do not complete the series, your bill will be reconciled at the individual treatment rate and any resulting credit can be applied only to a gift certificate or to additional services or products. In regards to the Weight Loss Program, if you withdraw from the program, you will not be entitled to a refund of any previously paid monies.

My signature on this form confers the authorization for Medical treatment by Inda Mowett, MD and her staff at The Aesthetic & Wellness Center.

Signature: _____ Date: _____

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MEDICAL HISTORY

Name: _____ Age: _____ Birth date: _____
Today's Date: _____ Last Physical/Bloodwork: _____
Primary Physician's Name: _____
Office phone # (Primary Care Physician): _____

What is your reason for your visit today?
___ Cosmetic Services ____ Weight Management ____ Mesotherapy

General Health History

___Autoimmune Deficiency
___Heart Attack
___Neurological Disease
___Eating Disorder
___Heart Disease
___Pacemaker
___Arthritis
___High Cholesterol
___Palpitations
___Asthma
___HIV/AIDS
___Psychiatric Care
___Bleeding Disorder
___Anemia
___Rheumatoid Fever
___Cancer
___Hypertension
___Skin Allergies
___Chemical Dependency
___Infection (active)
___Stroke
___Cold Sores/Fever Blisters
___Keloid Scar Formation
___Thyroid Disease
___Depression
___Kidney Disease
___Gout/Hyperuricemia
___Diabetes
___Liver Disease
___Emphysema/COPD
___Lung Disease
___Epilepsy/Seizures
___Migraine Headaches
___Gastric Reflux
___Multiple Sclerosis
___Surgery
(Please list below)

Other: _____

Allergies

* Medications: _____
* Food: _____
* Cosmetics: _____
* Latex/Other: _____
* Are you allergic to?

□ Lidocaine □ Strawberries □ Collagen
□ Beef □ Eggs/ Chicken

Current medications

_____
_____
_____
_____
_____

Social History

_____ Single _____ Married _____Widowed
Occupation:_____
Do you smoke cigarettes? _____
If yes, how many packs a day? _____
Do you drink alcohol? _____
If yes, weekly alcohol intake: _____

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Women only

Date of last menstrual period: _____
Are you pregnant? _____
Are trying to get pregnant? _____
Are you currently on hormone replacement? ___
Are you nursing? _____

Are you currently using contraception? _____
If yes, please provide name of medications: ____
_____
_____

Family History

Check if any of your blood relatives have had any of the following:

___ None ___ Cancer __ Diabetes __ Heart Disease __ Stroke __ Kidney Disease
___ Obesity ___ High Blood Pressure Other: _____

History of previous cosmetic treatments or procedures:

- □ Ablative Laser
- □ Laser Acne Treatments
- □ Botox
- □ Laser/IPL Hair Removal
- □ Cellulite Reduction
- □ Chemical Peels
- □ Microdermabrasion
- □ Dermal Fillers
- □ Permanent Make-Up
- □ IPL Fotofacial
- □ Skin Tightening

When did you have it done? _____

Are you currently taking/using?

__ Retin-A __ Renova __ Steroids ___ Prescription acne medication
Have you been taking Accutane for the past 12 months? _____
What line of skin products are you using? _____
_____

I understand the information on this form is essential to determine my medical and cosmetic needs and the provision of treatment. I understand that if any changes occur in my medical history/health I will report it to the office as soon as possible. I have read and understand the above medical history questionnaire. I acknowledge that all answers have been recorded truthfully and will not hold any staff member responsible for any errors or omissions that I have made in the completion of this form.

_____ _____
Print Name, Parent or Legal guardian Date

_____ _____
Signature Reviewed by/ Date

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What procedures are you interested in?

Check all that apply

Treatment sun damaged skin (brown spots)
___ Face
___ Neck
___ Chest
___ Hands
___ Arms/forearms
___ Legs

Removal of fine lines and wrinkles
___ Full face
___ Forehead
___ Crow's feet
___ Lower face
___ Neck
___ Face and neck

Facial veins & broken capillaries
___ Full face
___ Mid-face
___ Nose/Cheeks
___ Lower face

Treatment of Rosacea
___ Nose/Cheeks
___ Full face
___ Mid-face
___ Lower face
___ Neck
___ Chest

Skin Care Services
___ Microdermabrasion
___ Chemical Peels
___ Skin Rejuvenation
___ Hand Rejuvenation
___ Neck bands

____Weight Loss Programs
____ Pre-Wedding/Special Event
____ Aesthetic Services VIP Program

Dermal Fillers
___ Lip augmentation
___ Smile lines
___ Marionette's lines
___ Smoker's lines
___ Cheek augmentation
___ Lower lids/sunken eyes

Pulsed Light Hair Removal
___ Neck
___ Back
___ Chest
___ Abdomen
___ Underarms
___ Forearms
___ Upper arms
___ Beard (male)
___ Bikini Line
___ Full leg
___ Half Leg
___ Upper lip/chin

Botox
___ Frown lines
___ Forehead lines
___ Crow's feet
___ Smoker's lines
___ Bunny lines
___ Neck bands

Hormone Replacement Therapy
___ Hormonal imbalance
___ PMS
___ Pre-menopause
___ Menopause
___ Post-menopause
___ Thyroid Disease
___ Low Testosterone

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LIFE STYLE EVALUATION

Patient Name: _____ Age: _____ Date: _____

Please complete the following questions honestly and completely.

1. Present Weight: _____ lbs Height: _____ Date you'd like to reach your target weight? _____

2. Weight: one year ago: _____lbs at 20 yrs old:_____lbs What is your weight goal? _____

3. What was your lowest weight in the last 5 years? _____lbs.

4. When did you begin to gain weight? ☐ After childbirth ☐ After marriage ☐ After employment change ☐ During a stressful time ☐ Childhood ☐ Other (explain) _____

5. How long have you been overweight? ☐ 1 year or less ☐ 2 to 5 years ☐ 6 to 10 years ☐ >10 years

6. What do you feel is the reason for your weight problem? ☐ Frequent overeating ☐ Fattening foods ☐ Heredity ☐ Lack of exercise ☐ Other (explain) _____

7. How many meals do you eat each day? _____

8. How many serious attempts have you made at dieting? _____

9. How long have you been able to adhere to a diet? ☐ 0-1 month ☐ 2-6 months ☐ 7-12 months ☐ Over 12 months

10. What other weight reduction methods have you tried? ☐ Weight Watchers ☐ Other diet center ☐ Diet book ☐ Physician ☐ Prescription of appetite suppressants ☐ Over the counter diet products ☐ Do it yourself ☐ Other _____

11. Why did you drop out of diets before? ☐ Boredom ☐ Hunger ☐ Stress ☐ Needed assistance ☐ Other _____

12. What is the nature of your challenges when dieting? _____

13. Have you been advised by your physician to lose weight? ☐ Yes ☐ No

14. Do you have any physical problems that you know are associated with your weight? _____

15. Why do you want to lose weight? ☐ Social reasons ☐ Appearance ☐ Health reasons ☐ To please family/friends ☐ Special occasion (list) _____ ☐ Other (explain) _____

16. Has your husband/wife encouraged you to lose weight? ☐ Yes ☐ No Explain _____

17. How important is it to you to lose weight? ☐ Extremely Important ☐ Important ☐ Not very important

18. Do you work outside the home? ☐ No ☐ Part-time ☐ Full-time

19. Occupation _____

20. Marital Status: ____Married ____Divorced ____Single ____Widowed ____Living with a partner

21. Is your spouse or partner overweight? ☐ Yes ☐ No

22. Do you have children? ☐ Yes ☐ No Number of children: _____ Ages: _____

23. Are any of your children overweight? ☐ Yes ☐ No

24. How often do you eat out? _____

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LIFE STYLE EVALUATION CONTINUED

25. Which restaurants do you frequent? _____

26. How often do you eat fast food? ____ times per day ____ times per week

27. Who plans and prepares your meals? _____

28. Who does your grocery shopping? _____

29. What time of day, & what day do you grocery shop? _____

30. Do you use a shopping list? ☐ Yes ☐ No

31. Are you allergic to any foods? ☐ Yes ☐ No Explain_____

32. What type of foods do you dislike? _____

33. What type of foods do you crave? _____

34. Is there any specific time that you crave food?_____

35. Do you drink coffee or tea? ☐ Yes ☐ No If so, how much daily? _____

36. Do you drink sodas? ☐ Yes ☐ No If so, how much daily? _____What brand/flavor? _____

37. Do you drink alcohol? ☐ Yes ☐ No What type? _____ How much daily? _____

38. Do you use sugar substitutes? ☐ Yes ☐ No What type? _____

39. Do you awaken hungry at night? ☐ Yes ☐ No What time?: _____ Where: _____
What do you do? _____

40. What are your worst eating habits? _____

41. What are your snack habits? What? _____ When? _____How much? _____

42. When you are in a stressful situation, do you tend to eat more? ☐ Yes ☐ No

43. Are you currently dealing with a stressful situation? ☐ Yes ☐ No

44. Do you smoke? ☐ Yes ☐ No

45. What is your typical breakfast? _____
Time eaten: _____ Where: _____ With whom: _____

46. What is your typical lunch? _____
Time eaten: _____ Where: _____ With whom: _____

47. What is your typical dinner? _____
Time eaten: _____ Where: _____ With whom: _____

48. Describe your typical energy level: _____

49. Physical Activity (check one):
- ☐ Inactive *(No regular activity. Has a sit-down job.)*
- ☐ Light Activity *(No organized physical activity during leisure time.)*
- ☐ Moderate Activity *(Occasionally involved in activities such as weekend golf, tennis, walking, etc.)*
- ☐ Heavy Activity *(Consistent exercise at least 30 minutes 3 times per week).*

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Weight Loss Consumer Bill of Rights

WARNING:

- Rapid weight loss may cause serious health problems. Rapid weight loss is weight loss of more than 1 ½ pounds to 2 pounds per week or weight loss of more than 1 percent of body weight per week after the second week of participation in a weight loss program.
- Consult your physician before starting any weight-loss program.
- Only permanent lifestyle changes, such as making healthful food choices and increasing physical activity, promote long term weight loss.
- Qualifications of this provider are available upon request.
- You have a right to: ask questions about the potential health risks of this program and its nutritional content, psychological support, and educational components.
- Receive an itemized statement of the actual or estimated price of the weight loss program, including extra products, services, supplements, examinations, and laboratory tests.
- Know the actual or estimated duration of the program.
- Know the name, address and qualifications of the dietitian or nutritionist who has reviewed and approved the weight-loss program according to Section 468-505(1)(j), Florida Statutes.

Required to be posted by Section 501.0575 of Florida Statutes

I have read the above statement:

_____ _____

Patient's Name Printed **Date**

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Photography consent

I, _____ hereby authorize Dr. Inda Mowett or any member of her staff to take before and after picture(s) of the skin treatment, procedure or weight loss program I am receiving. These photograph(s) may be used for my file and only portions of my face or body will be placed in photo albums or slide presentations to show the results of my treatments.

_____ _____

Print Name Sign Name

_____

Date

If the above person is a minor (Under the age of 18), the signature of a parent or guardian is required below;

_____ _____

Print name of Parent or Guardian Signature of Parent or Guardian

_____

Date

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Patient Consent: Message and/or Appointment Reminders Per HIPAA Regulations

Today's Date _____

Patient Name: _____ DOB _____

May we leave the following types of messages at your home, work, cell, email or emergency number:

1.	Office appointment confirmation/changes	Yes	No
2.	Labs and/or outpatient test results	Yes	No
3.	Payment requirements for upcoming appointments	Yes	No
4.	When authorization, medical records, other info needed	Yes	No
5.	Prescription refill information	Yes	No

Acknowledgement of Receipt of Notice

As required by the privacy regulation, I hereby acknowledge that I have received a current copy of the privacy notice. I understand that is my responsibility to read through the given information, make any requests and provide documentation that may protect my confidentiality within this practice.

By way of signature, I provide Inda Mowett, MD with my authorization and consent to use and disclose my healthcare information for the purposes of treatment, payment and healthcare described in the privacy policies.

_____
Signature & Date

My healthcare information may be shared with the following persons:

_____
Name & relationship to patient

_____
Name & relationship to patient

No, my records may not be shared _____