Omni Cosmetic

Registration Form

(Please Print)

Today's Date:

PATIENT INFORMATION

Patient's Last Name: First: MI:			Nickname:
Birthdate: / /	Age:	Gender:	Social Security Number:
Street Address:	City:	State:	Zipcode:
P.O. Box:	Home Number:		Cell Number:
Occupation:	Employer:		Employer Phone:
Referred by (include name if applies)	☐ Web Search	☐ New Beauty	☐ Drive By
☐ Friend	☐ Family	☐ Dr.	☐ Other
Email Address:		May we add you to our email list? Yes ☐ No ☐	

INSURANCE INFORMATION

(Please give your insurance card and ID to the receptionist)

Primary Insurance:			Policy no:	Grp no:	Co-payment $
Patient's relationship to subscriber:	☐ Self	☐ Spouse	☐ Child	☐ Other	DOB (if not self) :

IN CASE OF EMERGENCY

Name of local friend or relative:	Relationship to patient:	Phone no:

I certify that the above information is correct. I understand that I am financially responsible for all services not paid by my insurance. I am also responsible for any deductibles, copayments or non-covered services. I authorize e Omni Cosmetic, Wayzata Surgical Center and/or Central MN Anesthesia Providers to release any medical or other information necessary to process my claims. I also request payment of payment of government or private benefits either to myself or to the party who accepts assignment. This is a permanent authorization that I may revoke at any time by written notice.

Privacy Practice and Insurance Acknowledgment

Under the Health Insurance and Portability and Accountability act of 1996 (HIPPA), you have certain rights regarding the use and disclosure of your protected health information. Thes se rights are more fully des scribed in Omni Cosmetic's Notice of Privacy Practices. Omni Cosmetic is permitted to to revise its Notice of Privacy Practices at any time. The undersigned acknowledges that you were offered an and or received the Minnesota Patient Bill of Rights & Privacy Policy information. I also understand that my insurance will be billed for all consultations related to billable medical conditions

Electronic Communication Consent

By signing below, I acknowledge that I am aware that communication between N Omni Cosmetic and myself may sometimes be through electronic communication, i.e.: email voice mail and/or text messaging. Communication of these types will be based on the comfortability of the individual patient/client. Each patient/client has the right to review or receive a copy of the communication policy upon request.

I _____ give my consent to N Omni Cosmet tic to release my medical information to the friend/family members listed. _____ (initials)

Name of person authorized to receive medical information on patient: _____

Print Patient Name: _____

Patient/Guardian signature: **Today's date:_____**

Name _____ Today's Date _____ Height _____ Weight _____

What brings you in today? _____ Age:

PAST AND CURRENT MEDICAL PROBLEMS

History Of	Yes/No	Specify
Anesthesia complications?	☐ ☐	
Sleep Apnea	☐ ☐	CPAP? Yes/No:
Excessive bleeding problems?	☐ ☐	
Taking Aspirin, Motrin, Advil, Etc.	☐ ☐	
High blood pressure?	☐ ☐	

PAST SURGICAL PROCEDURES WITH DATES

MEDICATION ALLERGIES **NONE KNOWN** ☐

CURRENT MEDICATIONS: PRESCRIPTION AND OVER-THE-COUNTER

MEDICATION	DOSE	FREQUENCY

PERSONAL HABITS	Yes/No	FREQUENCY
Tobacco	☐ ☐	
Alcohol	☐ ☐	
Recreational Drugs	☐ ☐	
Exercise	☐ ☐	
Occupation	☐ ☐	Specify type:
Any history of cold sores?	☐ ☐	

NUMBER OF PREGNANCIES _____ NUMBER OF CHILDREN _____

WEIGHT LOSS SURGERY? YES NO (If no, skip to Signature Line)

IF YES, WHEN? _____ BY WHOM? _____

COMPLICATIONS? YES NO EXPLAIN: _____

WEIGHT PRIOR TO SURGERY _____ PANT/DRESS SIZE PRIOR TO SURGERY _____

LOWEST WEIGHT AFTER SURGERY _____ PANT/DRESS SIZE AFTER SURGERY _____

DO YOU HAVE ABDOMINAL HERNIAS? YES NO IF YES, SPECIFY _____

HAVE YOU HAD ANY HERNIA REPAIRS? YES NO IF YES, SPECIFY _____

CURRENT BRA SIZE _____ DESIRED BRA SIZE _____ SIZE PRIOR TO PREGNANCY _____ SIZE DURING PREGNANCY _____

HISTORY OF	Yes/No	SPECIFY
Shoulder pain	☐ ☐	
Shoulder grooving	☐ ☐	
Breast pain	☐ ☐	
Numbness of hands/fingers	☐ ☐	
Neck pain	☐ ☐	

	Yes/No	
Upper Back Pain	☐ ☐	
Inframammary Rashes	☐ ☐	
Family history of breast cancer	☐ ☐	
Mammograms	☐ ☐	When: Result:
Trauma/Injury to breasts	☐ ☐	
Infections in breasts (Mastitis)	☐ ☐	
Breast feeding	☐ ☐	

I ACKNOWLEDGE THAT THE ABOVE INFORMATION IN COMPLETE & ACCURATE TO THE BEST OF MY KNOWLEDGE
SIGNATURE _____ DATE _____

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