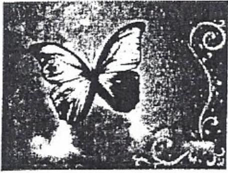

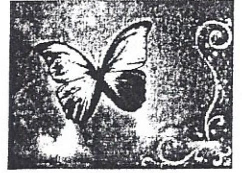

Gregory W. Nestor, M.D.

# THE MEDIAL CENTER OF BODY REJUVENATION PATIENT REGISTRATION FORM

## Information

Name:______________________________ Prefer to be called: ____________________

Address:______________________________City:____________State:________Zip____________

Phone (_____)______________ Work Phone (_____) ______________ Cell Phone (_____)________________

The best time to contact me is:______________ ☐ A.M. ☐ P.M. on my ☐ Home phone ☐ Work phone ☐ Cell phone

Date of Birth:____/____/______ Social Security#: _______-______-________ ______Female ______Male

Check Appropriate Box: ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Whom may we thank for referring you? ______________________________________

Person to contact in case of emergency______________________________ Phone____________________

Email Address:______________________________ Would you like to receive our e-newsletter? ☐ Yes ☐ No

Signature:______________________________ Date:____/____/________

## Section II

## VASER® PATIENT QUESTIONNAIRE

What areas of your body are you interested in having treated? ______________________________

Have you had any cosmetic surgery in the past? If yes, what procedure (s):______________________________

Are you familiar with the techniques used in other body sculpting procedures? ______________________________

Are you currently, or have you ever been on a weight loss program?______________________________

## The Medical Center of Body Rejuvenation

### Patient Medication List

Please fill out as completely as possible:

**NAME:** ______________________________________________
First Middle Last

**ALLERGIES TO MEDICATIONS** (Please Include Reaction): ______________________

______________________________________________

**ALL CURRENT MEDICATION/ VITAMINS** (Please List)

Are you currently taking: _____Aspirin _____ Coumadin

1. ______________________
2. ______________________
3. ______________________
4. ______________________
5. ______________________
6. ______________________
7. ______________________
8. ______________________
9. ______________________
10. ______________________
11. ______________________
12. ______________________
13. ______________________
14. ______________________
15. ______________________
16. ______________________
17. ______________________
18. ______________________
19. ______________________
20. ______________________

Are you Allergic to: **Lidocaine?** Yes ____ No ____ Reaction: ______________

**Latex?** Yes _____ No ____ Reaction: ______________

**Penicillin?** Yes _____ No ____ Reaction: ______________

**Epinephrine?** Yes _____ No ____ Reaction: ______________

**Have you ever Blacked/Passed out?** O YES O No If so, when?______________

Describe the circumstances: ______________________________

## Patient Consent for the Use and Disclosure of Health Information
### For Treatment, Payment, or Healthcare Operations as per HIPAA Regulations

I understand that as part of my health care, the Practice originates and maintains paper and/or electronic records describing my health history, symptoms, examinations and test results, diagnoses, treatments, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment
- A means of communication among health professionals who contribute to my care; such as referral
- A source of information for applying my diagnosis and treatment information to my bill
- A means by which a third-party payer can verify that services billed, were actually rendered
- A tool for routine healthcare operations, such as assessing quality and reviewing the competence of staff

**I have been advised that I can request a "*Notice of Patient Privacy Practice*" that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:**

- The right to review the "*Notice*" prior to acknowledging this consent
- The right to restrict or revoke the use or disclosure of my health information for other uses or purposes
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations

**PLEASE PRINT**

**Restrictions:**

**** I request the following restrictions be applied to the use and/or disclosure of my health information:**

---

---

****Please tell us with whom we may discuss your protected health information:**

- **Indicate their names and relationship to you**

---

---

****Messages and appointment Reminders:**

- **Messages will be of a non-sensitive nature**

Can we leave a message at your **Home** using Doctor's/Practice Name: Yes_______ No_______

Can we leave a message at your **Work** using Doctor's/Practice Name: Yes_______ No_______

**I understand that as part of treatment, payment or healthcare operations, it may become necessary to disclose health information to another entity. An example of this is processing referrals for your care to other healthcare providers. I consent to such disclosure for these uses as permitted by law.**

** I fully understand and accept / decline (circle one) the information of this consent.

Patient/Guardian ______________ Print Name ______________ Date ________

If person other than patient (patient name)______________ is signing, are you the legal guardian, custodian or have Power of Attorney for this patient for treatment, payment or healthcare operations? Yes__ No__

FOR OFFICE USE ONLY

{ } Consent form received and reviewed by ______________ on _____/_____/_______

{ } Consent form signature refused by Patient

{ } Patient unable to sign consent form - REASON:______________

*GREGORY NESTOR, . .D.* | *DEBC. .AH NOLAN, A.R.N.P.*

NAME__________ AGE_____ SEX_____ S M W D_____

ADDRESS__________ PHONE__________ DATE__________

NEXT OF KIN__________ ADDRESS__________

OCCUPATION__________ REFERRED BY__________

MEDICARE OR OTHER INSURANCE I.D.#__________ D.O.B.__________

WHAT MEDICAL DOCTOR DID YOU LAST SEE?__________ WHEN__________

1. What childhood illnesses have you had? __________

2. Did you have any unusual or severe illnesses prior to age 18? __________

3. Give the year or your age if you have had any of the following operations:

| | | |
|---|---|---|
| Tonsillectomy_____ | Hysterectomy_____ | Ear Operation_____ |
| Cataract Operation_____ | Prostate Operation_____ | Lung Operation_____ |
| Gall Bladder Removal_____ | Vein Operation_____ | Hernia_____ |
| Stomach Operation_____ | Appendectomy_____ | Artery Operation_____ |
| C-Section_____ | Eye Operation_____ | Heart_____ |
| Breast Surgery_____ | Hemorrhoidectory_____ | Others_____ |

4. If you have any of the following problems, please mark with an X:

| | | |
|---|---|---|
| Diabetes_____ | High Blood Pressure_____ | Prostate Problems_____ |
| Anemia_____ | Heart Trouble_____ | Lung Trouble_____ |
| Cancer_____ | Kidney or Bladder Trouble_____ | Stomach or Bowel Trouble_____ |
| Arthritis_____ | Female Problems_____ | |
| Depression_____ | Thyroid Problems_____ | |

5. If you have had any broken bones, whether right or left, and the year in which the injury occurred:__________

6. Give the years and reason if you have been hospitalized for anything besides injuries or operation:__________

7. Except as noted above, for what have you been treated by physicians during the past ten years other than common colds and the like: __________

8. What medicines do you now take and how often do you take them: __________

9. Have you ever had a blood transfusion? __________ When? __________ How Many? __________

10. List any medicines to which you are allergic: __________
    Have you ever had asthma or hay fever? __________

(OVER)

11. Women Only: At what age did your periods commence? ______
At what age did they stop? ______
What if any trouble do you have with your periods? ______
______
How many living children have you had? ______ How many still births? ______
How many miscarriages? ______

12. a. Occupation ______ Are you retired? ______
b. What is your spouse's age? ______
c. Do you consider him/her to be in good health? ______ If not, why not? ______
______
d. In what year were you married? ______ How many beers, shots, cocktails and highballs do you consume in an average week? ______
e. How many pipes, cigars, or packs of cigarettes do you smoke per day, on the average? ______
______
f. How many cups of coffee do you drink per day? ______ Tea ______
g. In what state were you born? ______ If foreign born, at what age did you come to this country? ______ In what state did you live most of your life? ______
h. Do you generally sleep well? ______
i. What are your principal hobbies or recreational activities? ______
j. If you were in the Armed Services, what branch and years? ______
______

13. LIVING / DECEASED

| | Age | State of Health | Chronic Diseases | Age at Death | Cause of Death | Other Illnesses |
|---|---|---|---|---|---|---|
| Father | | | | | | |
| Mother | | | | | | |
| Brothers | | | | | | |
| Sisters | | | | | | |
| Children | | | | | | |

Except as noted, have any close blood relatives had cancer? ______
______
High Blood Pressure? ______
Diabetes? ______
Tuberculosis? ______
Any disease that run in the family? ______

HOSPITAL DATA:

Admission Date: ______ Admission Diagnosis: ______
Lab data: ______
______
______

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