



**Office Information Sheet/ Patient Information**

On behalf of our providers and staff, we would like to take this opportunity to welcome you to Devenu. Thank you for your kind cooperation in filling out our information sheet.

**Patient Information**

Full name: \_\_\_\_\_ DOB: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Sex: Male \_\_\_\_\_ Female \_\_\_\_\_

Home phone: (\_\_\_\_) \_\_\_\_\_ Work phone: (\_\_\_\_) \_\_\_\_\_ Cell phone: (\_\_\_\_) \_\_\_\_\_

SSN: \_\_\_\_\_ Marital Status (please circle): S M W D

Employer/School: \_\_\_\_\_ Occupation: \_\_\_\_\_

To receive notification of special offers please provide your e-mail address here:

\_\_\_\_\_

To contact me please call: (check all that apply) home \_\_\_ work \_\_\_ cell \_\_\_

**Person Financially Responsible**

(If same as above please skip this section)

Name: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

SSN: \_\_\_\_\_ Employer: \_\_\_\_\_

Home phone: (\_\_\_\_) \_\_\_\_\_ Work phone: (\_\_\_\_) \_\_\_\_\_ Cell phone: (\_\_\_\_) \_\_\_\_\_

**Insurance Information**

Primary Insurance Company: \_\_\_\_\_ Phone number: (\_\_\_\_) \_\_\_\_\_

Policy Holder Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Policy Number: \_\_\_\_\_ Group Number: \_\_\_\_\_

**Emergency Contact**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Home Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home phone: (\_\_\_\_) \_\_\_\_\_ Work phone: (\_\_\_\_) \_\_\_\_\_ Cell phone: (\_\_\_\_) \_\_\_\_\_

Please list the name of your Primary Care Physician: \_\_\_\_\_

**Referral Information**

How did you hear about us? (please circle) newspaper internet television magazine friend physician other: \_\_\_\_\_



**Office Information Sheet/ Patient Information (cont.)**

**Release of Information**

I authorize Devenu Medical Rejuvenation Center and providers to release to my insurance carrier listed above, any medical information needed for authorization or payment of this or a related claim as necessary. I also authorize payments directly to this office for the medical benefits. I understand that I am financially responsible for all charges whether or not paid by my insurance. I understand that most cosmetic procedures will not be covered by my insurance.

I have also been advised that this office requires a 24-hour prior notice on all appointment cancellations. With failure to notify Devenu staff I understand I will be charged a set fee of \$100 dollars.

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Patient History**

Please list any medications, including prescription or over-the-counter medicines or vitamins that you are taking:

- 1. \_\_\_\_\_ Reason for taking: \_\_\_\_\_
- 2. \_\_\_\_\_ Reason for taking: \_\_\_\_\_
- 3. \_\_\_\_\_ Reason for taking: \_\_\_\_\_
- 4. \_\_\_\_\_ Reason for taking: \_\_\_\_\_
- 5. \_\_\_\_\_ Reason for taking: \_\_\_\_\_
- 6. \_\_\_\_\_ Reason for taking: \_\_\_\_\_

Please list any medication and/or environmental allergies you have and what reaction you will have with each allergy: \_\_\_\_\_

Are you allergic to latex?	Yes	No	Are you allergic to tape?	Yes	No
Do you smoke cigarettes?	Yes	No	Are you pregnant?	Yes	No
Do you chew tobacco?	Yes	No	Are you planning on Pregnancy?	Yes	No
Do you drink alcohol?	Yes	No	Are you breast feeding?	Yes	No
Do you use recreational drugs?	Yes	No			
Do you drink caffeine?	Yes	No			

Do you go tanning in a tanning bed or booth? Yes No If yes, how often? \_\_\_\_\_  
When was the last time you tanned or were out in the sun for tanning purposes? \_\_\_\_\_

**Patient History (cont.)**

Are you currently taking Accutane?      Yes    No    If yes, how long have you been on it? \_\_\_\_\_  
 Have you been on it in the past?      Yes    No    If yes, how long ago? \_\_\_\_\_

Are you currently on Retin A?            Yes    No    If yes, how long have you been on it? \_\_\_\_\_  
 Have you been on it in the past?      Yes    No    If yes, how long ago? \_\_\_\_\_

Have you had laser or Intense Pulsed Light treatments before?      Yes    No  
 If yes, how long ago? \_\_\_\_\_

Have you ever experienced hyperpigmentation (darkening of the skin)?      Yes    No  
 Have you ever experienced hypopigmentation (lightening of the skin)?      Yes    No

Have you had sclerotherapy treatment to leg veins before?      Yes    No  
 If yes, how long ago? \_\_\_\_\_  
 If yes, any complications? \_\_\_\_\_

Have you had microdermabrasion before?      Yes    No  
 If yes, how long ago? \_\_\_\_\_  
 If yes, any complications? \_\_\_\_\_

Have you had chemical peels before?      Yes    No  
 If yes, how long ago? \_\_\_\_\_  
 If yes, any complications? \_\_\_\_\_

Have you had LipoDissolve or liposuction before?      Yes    No  
 If yes, how long ago? \_\_\_\_\_  
 If yes, any complications? \_\_\_\_\_

Have you had Botox Cosmetic injections before?      Yes    No  
 If yes, how long ago? \_\_\_\_\_  
 If yes, any complications? \_\_\_\_\_

Have you had dermal fillers before (Restylan, collagen, etc.)      Yes    No  
 If yes, how long ago? \_\_\_\_\_  
 If yes, any complications? \_\_\_\_\_

**Skin**

Have you ever been treated for acne?      Yes    No  
 If yes, please explain: \_\_\_\_\_

Have you ever had skin cancer?      Yes    No  
 If yes, please explain: \_\_\_\_\_

**Patient History (cont.)**

Do you have problems healing? Yes    No  
 If yes, please explain: \_\_\_\_\_

Do you have a history of skin diseases? Yes    No  
 If yes, please explain: \_\_\_\_\_

Are you prone to cold sores?	Yes	No	Do you have eczema or psoriasis?	Yes	No
Do you have genital herpes?	Yes	No	Do you have rosacea?	Yes	No
Do you develop keloid scars?	Yes	No	Do you have sensitive or allergic skin?	Yes	No

**Your skin type is also defined by its level of oil production and its pore size. Mark the description (below) that most closely matches your skin:**

\_\_\_ **Dry skin type:** Your skin feels dry after washing, even with water only. You have small pores on your whole face, and rarely have blemishes. Your skin often feels tight and sensitive.

\_\_\_ **Normal Skin type:** Your skin feels fine after washing if you use a mild cleanser, and you rarely have blemishes. You can see larger pores along your T-zone (the area from your forehead down over the nose and on your chin), and sometimes you get clogged pores (blackheads) there.

\_\_\_ **Combination skin type:** Your T-zone (the area from your forehead down over the nose and on your chin) is oily, with larger pores that are visible. This area, especially the nose and chin, has occasional blemishes and clogged pores. However, the outer areas of your cheeks and forehead are dry, maybe even flaky when you use a cleanser strong enough to remove the oil on your T-zone.

\_\_\_ **Oily skin type:** You have a lot of oil on your face, and pores that are visible even on your outer cheeks. You need a strong cleanser to control the oil, and your face will be shiny by the end of the day. You get clogged pores (blackheads) easily, and will breakout if you do not clean your skin daily.

**Do you have now, or have you ever had diseases or conditions of:**

Artificial Joint	Yes	No	Hepatitis	Yes	No
Autoimmune Disease	Yes	No	High Blood Pressure	Yes	No
Blood Clots	Yes	No	HIV or AIDS	Yes	No
Phlebitis (Inflammation of the Vein)	Yes	No	Irregular Heart Beat	Yes	No
Convulsions or Epilepsy or Seizures	Yes	No	Lung Disease or Asthma	Yes	No
Diabetes	Yes	No	Pacemaker	Yes	No
Depression/Anxiety	Yes	No	Cancer	Yes	No
Heart Attack	Yes	No	Thyroid	Yes	No

**Patient History (cont.)**

**Past Surgical History:**

Date: \_\_\_/\_\_\_/\_\_\_  
 Date: \_\_\_/\_\_\_/\_\_\_  
 Date: \_\_\_/\_\_\_/\_\_\_

Procedure: \_\_\_\_\_  
 Procedure: \_\_\_\_\_  
 Procedure: \_\_\_\_\_

Pregnancy: # \_\_\_\_\_

Delivery: # \_\_\_\_\_

**Family History**

- Heart Disease
- Hypertension
- Stroke
- Cancer
- Diabetes
- Other
- None

Member Afflicted:

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Nutritional/Natural Supplements**

Please identify and list the products you are currently using:

Vitamins (single or multiple) \_\_\_\_\_

Minerals (Calcium, magnesium, etc.) \_\_\_\_\_

Nutrition/Protein Supplements (protein powders, amino acids, etc) \_\_\_\_\_

Others \_\_\_\_\_