FACE sarah hamilton

PATIENT INTAKE FORM

Patient Name: _____ DOB: _____ Today's Date: _____

Address: _____ City: _____ State: _____ Zip: _____

Home: (_____) _____ Cell: (_____) _____ Cell Phone Carrier _____

Email: _____

Emergency Contact: _____ Relation: _____ Phone: (_____) _____

Would you like to receive future monthly emails for promotional events, discounts, and specials from Sarah Hamilton FACE? (Y)☐ (N)☐
Please note: Your email address is used strictly for our communication with you and will not be given out.

Do you have a Brilliant Distinctions® account? (Y)☐ (N)☐

How did you hear about us?
Website/Internet☐ Social Media☐ Print Media☐ Other (please specify)☐ _____

Referred by a Patient?☐ *Name: _____

Are pregnant or breast feeding? (Y)☐ (N)☐

Do you have any neuromuscular or autoimmune diseases? (Y)☐ (N)☐ List: _____

Do you have any allergies? (Y)☐ (N)☐ Please List: _____

Allergic to latex? (Y)☐ (N)☐

Do you take Aspirin, Advil, Motrin, Ibuprofen, fish oils or anti-inflammatory meds more than once a week?

(Y)☐ (N)☐ If yes, please explain: _____

List all medications you are taking including antibiotics (prescription and over the counter):

_____

Do you have any allergies to medications? (Y)☐ (N)☐ If yes, please specify and state type of reactions:

_____

PATIENT'S SIGNATURE:
To the best of my knowledge, the information provided above is true and accurate.

_____ Patient's Signature Date: _____

Please Print Your Name: Provider's Signature:

_____ _____