Pinnacle 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 Pinnacle 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 Pinnacle Cosmetic's Notice of Privacy Practices. Pinnacle 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 Pinnacle 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 Pinnacle Cosmetic 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:_____

PINNACLE
COSMETIC

Name _____ **Today's Date** _____ **Height** _____ **Weight** _____

What brings you in today? _____ Age:

PAST AND CURRENT MEDICAL PROBLEMS

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

PAST SURGICAL PROCEDURES WITH DATES

MEDICATION ALLERGIES **NONE KNOWN** ☐

CURRENT MEDICATIONS: PRESCRIPTION AND OVER-THE-COUNTER

MEDICATION	DOSE	FREQUENCY

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

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

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

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