Youthful Images
Patient Information Date ______________________

Patient Name: ____
FIRST MIDDLE LAST

Name you prefer to be called: ______________________ Social Security #: ______________________

Address: ____

City: ______________________ State: ________ Zip: ____________

Marital Status: Married ____ Single ____ Date of Birth: ______________ Age: ______ Sex: ____M ____F

Race: ____ American Indian/Alaskan Native ____ Asian ____ Black or African American ____ Pacific Islander ____ Caucasian

Ethnicity: ____ Hispanic or Latino ____ Non-Hispanic or Latino

Home Phone Number: ______________________ Cell Phone Number: ______________________

Work Phone Number: ______________________ Ext: ______

I prefer to be contacted at my: home / cell / work phone number (please indicate)

_______ You may contact me at either number

E-mail address: ______________________ _______ You may contact me via the internet

Name and address of your Primary Care Physician:

____

If the patient is a minor, name and address of parent or guardian:

____

HOW WERE YOU REFERRED TO *YOUTHFUL IMAGES* ?

_________ web site – YouthfulImages.com _________ other web site * _________ friend or relative *

_________ physician * _________ other *

* please specify ____

CONSENT TO BE PHOTOGRAPHED
I consent to be photographed before, during and after my treatment. I understand that these photographs shall be the property of ***Youthful Images*** as a part of my permanent patient record, and will not be shared without my authorization.

Signature of Patient, Parent or Guardian ______________________________

CONSENT TO USE PHOTOGRAPHS
I understand and agree that my photographs may be used for internal patient education.

Signature of Patient, Parent or Guardian ______________________________

CONFIDENTIALITY AGREEMENT
I understand my records and photographs are strictly confidential. The contents of my records cannot be released to any person or organization without my prior written approval, excluding peer review.

Signature of Patient, Parent or Guardian ______________________________

CONSENT TO RELEASE INFORMATION
I hereby give permission to release and/or discuss information regarding my appointments, medical treatments, and related information to the following people:

Name: ______________________ Relationship to patient:: ______________

Signature of Patient, Parent or Guardian ______________________________

CONSENT TO RELEASE INFORMATION TO PRIMARY CARE PHYSICIAN
I understand and agree that information regarding my appointment will be released to my Primary Care Physician.

Signature of Patient, Parent or Guardian ______________________________

Our office is pleased to announce that we are now able to communicate information and promotions to patients digitally through means of email, texting, and our mobile application.

PLEASE INDICATE YOUR CHOICE TO PARTICIPATE OR NOT IN DIGITAL COMMUNICATION

_____ YES, I want to participate in the digital communication with professionals involved in my healthcare. I understand that I have the right to change my mind and can withdraw my permission by updating this form by checking the NO section and entering a revised date. At that point, my doctor will still be able to communicate with me through telephone, fax and traditional mail.

_____ NO, I do not (or no longer) want to participate in the digital communication with professionals involved in my healthcare. My doctor will still be able to communicate with me through telephone, fax and traditional mail.

____
Print patient name

____
Signature

____
Date

Patient Name: ____

We have found that the development of ***Youthful Images*** has been greatly enhanced through feedback from our patients. Your input is very important to us for future planning. Please indicate which of the following procedures may be of interest to you at present or in the future. If you would like additional information about any of the following procedures, please ask anyone here to help you. If you are interested in a procedure that you do not see listed, please let us know.

Cosmetic Surgery and Laser Services

Arm Lift
Augmentation of the Lips, Nasolabial Folds, Glabella or Minor Depressions
Botox Injections of Glabella or Crow's Feet
Breast Augmentation
Breast Lift
Breast Reduction
Buttock Lift
Cheek Augmentation
Chin Augmentation
Ear Pinning
Enlarged Male Breasts

Eyelid Lift
Face, Neck and Forehead Lift
Facial Liposculpturing
Fat Injections to the Nasolabial Folds or Glabella
Laser Resurfacing of Face
Liposuction
Nose Reshaping
Spider Vein Treatment
Thigh Lift
Tummy Tuck
Other ______________________________

Skin Care Services

BioMedic MicroPeel for the Face, Neck or Hands
BioMedic MicroPeel Plus for the Face
Hair Removal via and Lightsheer laser
Parisian Peel

Photorejuvenation
Rejuvenize Peel
Vipeel
Vitalize Peel
Other______________________________

Referrals from our patients are received with a great deal of appreciation and confidentiality. If you know of anyone who would be interested in receiving information regarding ***Youthful Images***, please feel free to request information or leave their name and e-mail address with us. We will be certain to forward the requested information.