The Aesthetic & Wellness Center
Restoring your health and beauty
5219 State Rd. 64 East, Bradenton, Fl | 941.749.0741

PATIENT INFORMATION FORM

Name: (Last) _____ (First) _____ (M.I.) _____ Sex: (M / F)
SSN (Required for Weight Loss Program):_____ Birth Date:_____ Age: _____
Home Address: _____
City: _____ State: _____ Zip Code: _____
Home Phone: ( ) _____ Cell Phone: ( ) _____
Best number to reach you: _____

E-mail appointment reminders: _____Yes _____No
Text message appointment reminders: _____ Yes _____No ****Cell # provider:** _____
E-Newsletter & Promotions: _____Yes _____No
Email: _____
(You will receive a welcome e-mail or text from us to confirm your appointment reminder preference)

Employment Information:
Employer: _____ Occupation:_____
Phone: ( ) _____ ext: _____
In Case of Emergency:
Name: _____ Relationship: _____ Phone: ( )_____

How did you hear about us?

- □ Magazine
- □ Physician Office
- □ Newsletter
- □ Referral by Current Patient
- □ Sign/Location
- □ Seminar
- □ Coupon Book
- □ Gyms
- □ Local Salon/Spa
- □ Radio advertising
- □ Television
- □ Internet Promotion
- □ Facebook
- □ Website
- □ Internet search

Financial Policy:
Please be advised that full payment for all services will be due at the time services are rendered. For your convenience we accept Visa, Master Card, Discover, Debit Card or Cash. We DO NOT accept personal checks.

No Show or Cancelled Appointment Policy:
We do not accept clients without appointments. Appointments that are not cancelled 24 hours prior to appointment time will be billed a $25.00 cancellation fee. Cancellation or no-show fees must be paid prior to making future appointments and are the sole responsibility of the client. Lipotropic injections missed cannot be credited for future injections. Repeat cancelled, or no-show appointments may result in termination from treatment at this practice.

Cancellation Policy
If you purchase an aesthetic treatment package and do not complete the series, your bill will be reconciled at the individual treatment rate and any resulting credit can be applied only to a gift certificate or to additional services or products. In regards to the Weight Loss Program, if you withdraw from the program, you will not be entitled to a refund of any previously paid monies.

My signature on this form confers the authorization for Medical treatment by Inda Mowett, MD and her staff at The Aesthetic & Wellness Center.

Signature: _____ Date: _____

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Patient Medical History

Name	Today's Date
Reason for visit	

General Health History:

	Anemia		Diabetes		Asthma
	Cancer		Palpitations		Heart disease
	High Blood Pressure		Low Blood Pressure		Kidney disease
	Liver disease		Neurological Disease		Eating Disorder
	Thyroid problems		Pacemaker		High Cholesterol
	Arthritis		HIV/AIDS		Bleeding Disorder
	Rheumatoid Fever		Skin Allergies		Stroke
	Kidney Disease		Emphysema/COPD		Epilepsy/Seizures
	Migraine Headaches		Gastric Reflux		Autoimmune Deficiency

List any previous procedures or surgeries and when (date) you had them done:

Allergies:

	No drug allergies		Aspirin		Codeine
	Penicillin		Iodine		Diagnostic dyes
	Strawberry		Eggs		Nuts
	Sulfa drugs		OTHER – (please list)		

_____ Non-smoker _____ Former smoker - how long ago did you quit?_____ Years

_____Smoker, how much? _____ Packs per day – How long have you smoked?_____Years

_____Drink alcohol – How much and how often?_____

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Social History: _____ Single _____ Married _____Widowed

Occupation: _____

Are you currently using any medications (prescription or non-prescription) and/or nutritional supplements/vitamins? Please list:

Name of Medication/Supplements	Dosage	Frequency

Women only

Date of last menstrual period: _____
Are you pregnant? _____
Are trying to get pregnant? _____
Are you currently on hormone replacement? _
Are you nursing? _____

Are you currently using contraception? _____
_____
If yes, please provide name of medications: __
_____

Family History

Check if any of your blood relatives have had any of the following:

___ None ___ Cancer ____ Diabetes _____ Heart Disease _____ Stroke ____ Kidney Disease

___ Obesity ___ High Blood Pressure Other: _____

I understand the information on this form is essential to determine my medical and cosmetic needs and the provision of treatment. I understand that if any changes occur in my medical history/health I will report it to the office as soon as possible. I have read and understand the above medical history questionnaire. I acknowledge that all answers have been recorded truthfully and will not hold any staff member responsible for any errors or omissions that I have made in the completion of this form.

_____ _____
Print Name Date

_____ _____
Signature Reviewed by/ Date

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What procedures are you interested in?

Check all that apply

Treatment sun damaged skin (brown spots)
___ Face
___ Neck
___ Chest
___ Hands
___ Arms/forearms
___ Legs

Removal of fine lines and wrinkles
___ Full face
___ Forehead
___ Crow's feet
___ Lower face
___ Neck
___ Face and neck

Facial veins/Broken Capillaries/Rosacea
___ Full face
___ Mid-face
___ Nose/Cheeks
___ Lower face

Skin Care Services (other)
___ Microdermabrasion
___ Chemical Peels
___ Micro-Needling
___ Skin Rejuvenation
___ Hand Rejuvenation
___Double chin/Jowls/Eye Fat pads
___Aesthetic VIP Membership

Wellness Testing
___ Metabolic Testing & Evaluation
___ Nutritional Testing & Evaluation
___ Food Sensitivities Testing & Evaluation

Medical Fitness
___Private Fitness Session
___Group Training Classes
___Pre-Natal Exercises
___Yoga Classes

Injectable Fillers (Juvederm/Restylane/Radiesse)
___ Lip augmentation
___ Smile lines
___ Marionette's lines
___ Smoker's lines
___ Volume correction-cheeks/mid- face
___ Lower lids/sunken eyes

Pulsed Light Hair Removal
___ Neck
___ Back
___ Chest
___ Abdomen
___ Underarms
___ Forearms
___ Upper arms
___ Beard (male)
___ Bikini Line
___ Full leg
___ Half Leg
___ Upper lip/chin

Botox
___ Frown lines
___ Forehead lines
___ Crow's feet
___ Smoker's lines
___ Nose lines
___ Neck bands/wrinkles

Hormone Replacement Therapy
___ Hormonal imbalance
___ PMS
___ Pre-menopause
___ Menopause
___ Post-menopause
___ Thyroid Disease
___ Low Testosterone

___**Weight Loss Management**

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LIFE STYLE EVALUATION

Patient Name:_____ Age: _____ Date: _____

Please complete the following questions honestly and completely

1. Present Weight: _____lbs Height: _____Date you'd like to reach your target weight?_____

2. Weight: one year ago: _____lbs at 20 yrs old: _____ lbs ~ What is your weight goal?_____

3. What was your lowest weight in the last 5 years?_____lbs.

4. When did you begin to gain weight? ☐ After childbirth ☐ After marriage ☐ After employment change ☐ During a stressful time ☐ Childhood ☐ Other (explain) _____

5. How long have you been overweight? ☐ 1 year or less ☐ 2 to 5 years ☐ 6 to 10 years ☐ > 10 years

6. What do you feel is the reason for your weight problem? ☐ Frequent overeating ☐ Fattening foods ☐ Heredity ☐ Lack of exercise ☐ Other (explain) _____

7. How many meals do you eat each day?_____

8. How many serious attempts have you made at dieting?_____

9. How long have you been able to adhere to a diet? ☐ 0-1 month ☐ 2-6 months ☐ 7-12 months ☐Over 12

10. What other weight reduction methods have you tried? ☐ Weight Watchers ☐ Other diet center ☐ Diet book ☐ Physician ☐ Prescription of appetite suppressants ☐ Over the counter diet products ☐ Do it yourself ☐ Other _____

11. Why did you drop out of diets before? ☐ Boredom ☐ Hunger ☐ Stress ☐ Needed assistance ☐Other _____

12. What is the nature of your challenges when dieting?_____

13. Have you been advised by your physician to lose weight? ☐ Yes ☐ No

14. Do you have any physical problems that you know are associated with your weight?_____

_____

15. Why do you want to lose weight?☐Social reasons ☐ Appearance ☐ Health reasons ☐To please family/friends ☐Special occasion (list)_____ ☐ Other (explain) _____

16. Has your husband/wife encouraged you to lose weight?☐ Yes ☐ No Explain: _____

17. How important is it to you to lose weight? ☐ Extremely Important ☐ Important ☐ Not very important

18. Do you work outside the home? ☐ No ☐ Part-time ☐ Full-time Occupation:_____

19. Marital Status: ____Married ____Divorced ____Single ____Widowed ____Living with a partner

Is your spouse or partner overweight? ☐ Yes ☐ No

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LIFE STYLE EVALUATION CONTINUED

20. Do you have children? ☐ Yes ☐ No Number of children: _____ Ages: _____

21. Are any of your children overweight? ☐ Yes ☐ No

22. How often do you eat out? _____

How often do you eat fast food? _____ times per day _____ times per week

23. On your workdays: Do you bring your own lunch? ☐ Yes ☐ No Do you skip lunch? ☐ Yes ☐ No

Do you eat out? ☐ Yes ☐ No ____ times per week

24. Who plans and prepares your meals? _____ When? _____

25. Who does your grocery shopping? _____ When? _____

26. Do you use a shopping list? ☐ Yes ☐ No

27. Are you allergic to any foods? ☐ Yes ☐ No Explain: _____

28. What type of foods do you dislike? _____

29. What type of foods do you crave? _____

30. Is there any specific time that you crave food? _____

31. Do you drink coffee or tea? ☐ Yes ☐ No ~ If so, how much daily? _____

32. Do you drink sodas? ☐ Yes ☐ No ~ If so, how much daily? _____ What brand/flavor? _____

33. Do you drink alcohol? ☐ Yes ☐ No ~ What type? _____ How much daily? _____

34. Do you use sugar substitutes? ☐ Yes ☐ No ~ What type? _____

35. Do you awaken hungry at night? ☐ Yes ☐ No ~ What time?: _____ Where: _____

What do you do? _____

36. What are your worst eating habits? _____

37. What are your snack habits? What? _____ When? _____ How much? _____

38. When you are in a stressful situation, do you tend to eat more? ☐ Yes ☐ No

39. Are you currently dealing with a stressful situation? ☐ Yes ☐ No Do you smoke? ☐ Yes ☐ No

40. What is your typical breakfast? _____

Time eaten: _____ Where: _____ With whom: _____

41. What is your typical lunch? _____

Time eaten: _____ Where: _____ With whom: _____

42. What is your typical dinner? _____

Time eaten: _____ Where: _____ With whom: _____

43. Describe your typical energy level: _____

44. Physical Activity (check one): ☐ Inactive *(No regular activity. Has a sit-down job.)*

☐ Light Activity (*No organized physical activity during leisure time.)*

☐ Moderate Activity (*Occasionally involved in activities such as weekend golf, tennis, walking, etc.)*

☐ Heavy Activity *(Consistent exercise at least 30 minutes 3 times per week)*

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Weight Loss Consumer Bill of Rights

WARNING:

- Rapid weight loss may cause serious health problems. Rapid weight loss is weight loss of more than 1 ½ pounds to 2 pounds per week or weight loss of more than 1 percent of body weight per week after the second week of participation in a weight loss program.
- Consult your physician before starting any weight-loss program.
- Only permanent lifestyle changes, such as making healthful food choices and increasing physical activity, promote long term weight loss.
- Qualifications of this provider are available upon request.
- You have a right to: ask questions about the potential health risks of this program and its nutritional content, psychological support, and educational components.
- Receive an itemized statement of the actual or estimated price of the weight loss program, including extra products, services, supplements, examinations, and laboratory tests.
- Know the actual or estimated duration of the program.
- Know the name, address and qualifications of the dietitian or nutritionist who has reviewed and approved the weight-loss program according to Section 468-505(1)(j), Florida Statutes.

Required to be posted by Section 501.0575 of Florida Statutes

I have read the above statement:

_____ _____

Patient's Name Printed **Date**

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Patient Consent: Message and/or Appointment Reminders Per HIPAA Regulations

Today's Date _____
Patient Name:_____DOB:_____

May we leave the following types of messages at your home, work, cell phone number, personal email or:

1.	Office appointment reminders/changes	Yes	No
2.	Labs and/or outpatient test results	Yes	No
3.	Payment requirements for upcoming appointments	Yes	No
4.	When authorization, medical records, other info needed	Yes	No
5.	Prescription refill information	Yes	No
6.	Receive office emails to my personal email account	Yes	No
7.	Receive my before and after photos to my personal email account	Yes	No

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Acknowledgement of Receipt of Notice

As required by the privacy regulation, I hereby acknowledge that I have received a current copy of the privacy notice. You can find a copy of HIPPA form at our website wwww.tawcenter.com under office forms tab. I understand that is my responsibility to read through the given information, make any requests and provide documentation that may protect my confidentiality within this practice.

By way of signature, I provide Inda Mowett, MD with my authorization and consent to use and disclose my healthcare information for the purposes of treatment, payment and healthcare described in the privacy policies.

_____
Signature & Date

My healthcare information may be shared with the following persons:

_____
Name & relationship to patient

_____
Name & relationship to patient

No, my records may not be shared _____

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Dear Patient:

As a member of the Obesity Medical Association and the American Board of Obesity Medicine, I am obliged to comply with certain regulations regarding the Weight Loss Program. These have been developed in the interest of providing the best possible care to the patients. As a part of these regulations, each patient must have bloodwork and an EKG before beginning the Weight Loss Program.

The specific tests required are:

1. CBC with differential
2. CMP
3. TSH
4. Lipid Profile
5. EKG

If you have had these tests done at your physician's office within the past 6 months, you can bring a copy to us the day of your visit, or have your physician fax it to us at 941-748-8426. If you have not had this done recently, you can have it done through our office (Bloodwork $100, EKG $49).

_____ _____

Signature Date

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Attendance and Cancellation/No Show Policy

Dear Valued Patient/Client:

We understand that unanticipated events happen occasionally in everyone's life. In our desire to be effective and fair to all clients, the following policies are in effect for recurrent tardiness and missed appointments

- **24 hour advance notice** is required when cancelling an appointment. This allows for someone else to schedule an appointment during that time. If you are unable to give us 24 hours advance notice you will be charged $25 for your missed appointment, including voicemails left with l**ess** than 24hour notice. This amount must be paid prior to your next scheduled appointment or charged to your credit card on file.

- **Payment Method** - Visa, MasterCard, Discover, American Express and cash. Checks are not accepted.

- **No-shows**
  Anyone who either forgets or consciously chooses to miss their scheduled appointment for any reason will be considered a "no-show." They will be charged $25 for their "missed" appointment.

- **Late Arrivals**
  If you arrive late, your session will be shortened in order to accommodate others whose appointments follow yours. Depending upon how late you arrive, your appointment may to be rescheduled. Regardless of the length of the treatment actually given, **you will be responsible for the payment of the "full" session**. **Please** plan accordingly and be punctual.

- **No Refunds**
  No refunds will be issued for deposits made if cancellation was not received within 24 hours before scheduled appointment. There will be no refunds provided for unused portions of a weight loss program. Medication and lipo injections are also non-refundable and non-transferable

- **Pre-paid cycles**
  Weight loss patients who have pre-paid for a cycle and have to cancel with notice a scheduled appointment will receive credit towards the next month's payment. Unused weeks will be reconciled at the weekly rate

Sincerely,

Inda Mowett, MD

By signing below, I authorize TAWC to charge the account $25 for cancelling or no show for my schedule appointment. I understand that TAWC may continue to charge my account if time after scheduling an appointment I do not notify the office 24 hour prior to my visit. Or cancel my membership in accordance to the terms, rules, regulations and conditions of this agreement. Additionally, I authorize TAWC to charge my credit/debit card on file in lieu of receiving additional services, at my request. You acknowledge receiving and reading a copy of this agreement.

I hereby authorize TAWC to keep swiped credit card information on file and to charge this card if necessary in accordance with the terms of this agreement.

_____ _____
Print Name Date

_____ _____
Signature Date