New Patient Information

Welcome to Saving Face, LLC. Thank you for your cooperation in completing these forms. Please read and complete all pages. *Please Print*.

Date	Patient's Name						Home Phone
Street Address							Work Extension
City, State, Zip				**Race:**			Cell
S. S. #		**Marital Status**					Pager
		S	M	W	D	Sep	
Birth Date	Age	**Sex**					Fax
		M		F			
Spouse or Parent's Name and Address							Email
Spouse or Parent's Employer		Spouse or Parent's S. S. N.					Driver's license / State
Spouse or Parent's Employer Address							Spouse or Parent's Work Phone
Emergency Contact – List 2		Are you a previous patient of Saving Face or RPPS? ☐ Yes ☐ No					Spouse or Parent's Occupation
Name and Address							Name and Address
Relationship							Relationship
Home Phone							Home Phone
Work Phone							Work Phone

Employment – check appropriate boxes

Occupation	☐ Full Time ☐ Part Time	☐ Full Time Student ☐ Part Time Student	☐ Retired ☐ Other:	Injured on the job?	☐ Yes ☐ No
Patient's or Parent's Employer		Date of Current Illness or Accident:			
Manager's Name		Who to contact at work:			
Employer's Street Address		City, State, Zip			

Referral

Referred by:	**Medical Doctor:**
Name and address of Attorney (If any)	

If greater than 1 year since you updated this form, ☐ Above information correct? Date: _____ Initials of patient or parent: _____
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Saving Face, LLC

1011 N. Lindsay St., Suite 201, High Point, NC 27262 • (336) 886-4114 • Fax: (336) 886-5536

HISTORY FORM

Date: «Appointment_Date» Name: «Person_First_Name» «Person_Middle_Initial» «Person_Last_Name»

Date of Birth: «Person_Birth_Date» Primary Care and/or Medical Doctor: _____

Current Medications (including vitamins and herbs): _____

_____

Drug Allergies: _____ Circle Reaction: rash, nausea, itching, other _____

_____ _____

List Previous Surgeries and Dates: _____

_____

_____

Previous Botox and/or fillers: ☐ YES ☐ NO Date:_____ Where?_____

Do you have a history of :

Heart Disease	☐ YES ☐ NO	Liver Disease	☐ YES ☐ NO
High Blood Pressure	☐ YES ☐ NO	Auto-Immune Disorders	☐ YES ☐ NO
Mental Disease	☐ YES ☐ NO	Neuro-muscular Disease	☐ YES ☐ NO
Bleed or Bruise Easily	☐ YES ☐ NO	Cancer	☐ YES ☐ NO
Diabetes	☐ YES ☐ NO	Cold Sores/Fever Blisters	☐ YES ☐ NO

Other: _____

If you answered "YES" to any of the above questions, please provide details:

_____

_____

_____

_____

Are you Pregnant? ☐ YES ☐ NO Nursing? ☐ YES ☐ NO

Do you smoke? ☐ YES ☐ NO packs/day _____

Do you drink alcohol? ☐ YES ☐ NO Alcohol per week: _____

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