# *Baum Beauty*

## Patient Registration

Patient name (first & last): _____ Date of Birth: ___ / ___ / ___
Cell Phone # (____)_____-_____ Email:_____
Address_____
City:_____ State:_____ Zip_____
Ethnicity / Race: _____
Primary Language: English / Spanish / Other_____
Preferred method of communication: Cell Phone / Text / E-mail / Mail

## Emergency Contact Info

Name: _____ Relationship to patient: _____
Emergency contact cell phone # (_____)_____-_____ Work # (_____)_____-_____
Address:_____
City: _____ State_____ Zip _____

| **Medication/Name** | **Dose/Frequency** |
|---|---|
| _____ | _____/_____ |
| _____ | _____/_____ |
| _____ | _____/_____ |

## Medical History

Yes___ No___ Do you have any bleeding disorders?
Yes___ No___ Are you currently taking any blood thinners?
Yes___ No___ Are you currently taking fish oil, vitamin E, ibuprofen, aspirin, or Aleve?
Yes___ No___ Are you currently taking any herbal supplements?
If yes, what?_____ **(all of the above will increase the risk of bruising or bleeding)**
Yes___ No___ Do you have the tendency to bruise or bleed easily?

# Baum Beauty

Any allergies to medication(s)? If yes

| **MEDICATION** | **REACTION** |
| --- | --- |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

Yes___ No___ Are you allergic to latex?
Yes___ No___ Have you ever had botox before?

Date of last botox treatment? ____ / _____ / _____