cosmetic surgical Nuts & REJUVENATION of OKLAHOMA

12324 St Andrews Dr.
OKC, OK 73120
405-607-1333 (office) **405-607-1330 fax**

Michell Cohn, D.O. Kathleen Pollard, RN Season Cox, RN

Patient Information

DATE_____

Patient Name:_____ Birth Date_____ Age_____
Last First MI

Address:_____|_____|_____|____|_____
Street Address Apt # City State Zip

Hm Phone:(_____)_____ Cell Phone or Pager (____)_____SSN_____/_____/_____

May we contact you via email? Yes No Email Address:_____

Patient's Employer **Information**:

Employer_____Work Phone (____)_____ How long_____

City, State_____ Position_____ Can we reach you at work YES NO

Spouse's Information:

Spouse or other Parent's name_____ Phone _____

(Nearest relative not living with you to notify in case of emergency)

Name _____ Relationship _____

City, State _____ Hm Phone (_____)_____ Wk Phone (____)_____

MEDICAL HISTORY

Circle any of the following that you have experienced:

Thyroid therapy	Steroid therapy	Venereal disease	Profuse bleeding	other stomach trouble
Lung trouble	Kidney trouble	Frequent headache	Heart trouble	other blood problems
Kidney disease	Psoriasis	Keloid scars	Chemotherapy	High blood pressure
Hay fever	Yellow Jaundice	Rashes	Paralysis	Nervous breakdown
Dizziness	Shingles	Blood disorders	Cancer or radiation	Drug abuse therapy
Bladder trouble	Excessive scarring	Skin infection	Skin pigmentation	Gall bladder trouble
Asthma	Diabetes	Skin irritation	Convulsions	Bouts of unhappiness
Arthritis	Stomach ulcers	Fever blisters	Hormone therapy	Psychiatric therapy
Anemia	Visual problems	Genital herpes	Burns/grafted skin	
AIDS	Excessive bruising	Liver trouble	Poor circulation	Frequent chest pain
Acne	Herpes (or cold sores)	Melanoma	Bouts of depression	Alcohol abuse therapy

Do you have any other medical problems that have not been covered?_____

_____

Please circle race: Caucasian African American Hispanic Asian Other:_____

Do you smoke 10+ cigarettes a day? YES NO Do you drink more than 6 cups of coffee a day? YES NO

Do you usually take two or more alcoholic drinks a day? YES NO

Have you had any previous surgery: YES NO Please list them:_____

_____

Are you now taking any drugs or medications? YES NO Please list them:_____

_____

Are you allergic to any medications, creams, tapes, ect? YES NO _____

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(WOMEN ONLY)

Date of your last menstrual period?_____ Are your periods often irregular? YES NO

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Who is your family doctor?_____ Phone number_____

May we contact your doctor for additional information pertaining to your health, if necessary? YES NO

How did you hear about us? Please check all statements that apply:

[ ] My friend told me about the doctor **(If you would like us to add a $50 credit to your friends account, as a gift of thanks, please list his/her name here _____**

[ ] My doctor, Dr. _____ referred me.

[ ] I saw you driving by [ ] I wanted to see a Board Certified Cosmetic Surgeon

[ ] I found you on Google [ ] I found you on Yahoo

[ ] I visited your website [ ] Other_____

Medical treatments of interest to you (Please circle all that apply)

Derma Fillers or Dysport®:

Sculptra™ Restylane™ Restylane Lyft™ Restylane Silk™ Restylane Refyne™
Restylane Defyne™ Kybella™ Facial Fat transfer Lip enhancement

PDO Thread Lifts:

Eyelid Lifting Brow Lift Mid or Lower Face Lifting Upper Lip Lift

Laser Treatments:

IPL Skin Rejuvention Skin Tightening Body Contouring

Skin Care:

Chemical resurfacing Peptide 9 Retinal 2.0 Vitamin C&E HA Moisturizer Cleansers

Surgical Procedures:

Tummy Tuck Liposuction Breast Lifting Breast Enlargement Breast Reduction
Thigh lift Earring tears

PLEASE BE ADVISED THAT WE DO NOT FILE INSURANCE. We DO NOT accept personal checks. PAMENT IS DUE AT THE TIME SERVICE IS RENDERED.

I agree that all of the information contained above is true and correct to the best of my knowledge.

Signature:_____ Date:_____