1850 W Lake Houston Pkwy suite 170 | Kingwood TX, 77706
P: (832) 644-8338 F: (832) 644-9560

renovekingwood@gmail.com

Appointment Date:			
Patient's Last Name:		Patient's First Name:	
Birthdate:	Age:	Gender:	Occupation:
Street Address:			
City:	State:		Zip Code:
Preferred Phone Number:		Email Address:	
Emergency Contact Name:	Emergency Contact Number:		Relationship to Patient:

Who may we thank for referring you to our office?
_____

The above information is true to the best of my knowledge. I understand that I am financially responsible for any charges for services provided.

Signature:_____ Date:_____
(Patient or Guardian)

Thank you for completing the registration form. Please let us know if you have any questions. We promise to provide a comfortable, positive experience at Renove Medical Spa.

Patient Medical History Form

Please print information clearly below. Let us know if you have any questions.

Patient's Last Name:		First Name:
Birth Date:	Height:	Weight:

Reason(s) for Consultation:

Have you ever been diagnosed with any of the following skin conditions?

	Heat urticaria or hives		Collagen disorders
	Vitiligo		Herpes/cold sores/fever blisters
	Eczema		Skin cancer
	Psoriasis		Sensitivity or allergy to the sun
	Melasma		Abnormal scarring/Keloid

Medical History (Please check any medical conditions that may apply to you)

	Diabetes		Hernia repair
	High blood pressure		Heart disease
	Lung disease or asthma		Autoimmune disorders (like lupus)
	Anemia or blood disorders		Seizures
	Stroke		HIV infection
	Cancer within the last 5 years		Hepatitis
	Pacemaker or defibrillator		Psychiatric disorders
	Renal failure		Metal plates, implants or devices
	Abdominal or colon surgery		History of radiation
	Hormone imbalance/PCOS or Thyroid disorder		

Current Medications (prescription, over the counter, vitamins & supplements):

Have you ever had an allergic reaction to the following? (please check those that apply):

	Latex		Lidocaine		Anesthesia		Topical Anesthetic		Other:

Drug Allergies:	**Reactions:**

Have you taken any of the following medications in the last 6 months?

Doxycycline, Minocycline, Tetracycline	Blood thinners	Accutane or similar pill

Have you had any of the following cosmetic procedures?

O Botox or Dysport	o Laser Resurfacing/Radiofrequency
O Leg Vein Treatment/Sclerotherapy	o Chemical Peels
o Dermal Fillers	o Surgery
o Photofacial/IPL treatments	o Laser Hair Removal
O Microdermabrasion	o Microneedling

Have you had any complications from previous cosmetic surgeries or procedures?

What is your current skin care regimen?_____

Have you used any of the following medications in the last 2 weeks:

	Cortisone		Retin A		Glycolic Acid
	Clindamycin		DesquamX/Zerac		Lactic Acid
	Metrogel		Tazoratene		Salicylic Acid

Have you smoked in the past year?	Yes	No
Do you use any other tobacco products?	Yes	No
Do you drink alcoholic beverages? How often?	Yes	No
Have you used any tanning beds, lamps, or products in the last 6 weeks?	Yes	No
Do you have any permanent makeup or tattoos in an area being treated?	Yes	No

Which of the following best describes your skin type?

	Always burns never tans
	Always burns sometimes tans
	Sometimes burns always tans
	Rarely burns always tans
	Brown, moderately pigmented skin
	Black skin

What is your ethnic background?_____

Women Only:

Are you pregnant or nursing?	Yes	No
Do you have a history of Polycystic ovarian Syndrome?	Yes	No
Do you have an IUD?	Yes	No
Do you leak urine when you cough, sneeze, jump etc.?	Yes	No
Do you have an urgency to use the restroom?	Yes	No
Do you have an underactive sex drive?	Yes	No
Do you have pain during intercourse?	Yes	No
Do you have a problem reaching climax?	Yes	No

Men Only:

Do you suffer from erectile dysfunction?	Yes	No

Is there any other essential information that we need to know? Please use the space below:

Person(s) authorized to discuss my protected medical information and receive copies of my medical history records are:

_____

Authorized Name Relationship Date

I certify that the information provided on this medical history form is correct and complete. Further, I understand that providing incomplete and incorrect information may not only jeopardize my health, but also render ineffective or harmful, any treatment I receive from Dr. Afia Navi, Toni Cervantes, Danila Velez.

Signature:_____ Date:_____

Thank you for completing your medical history form.

RÉNOVE
MEDICAL SPA

Health Assessment for Men

Name: _____ Date: _____

E-Mail: _____

SYMPTOMS (please check Box)	Never	Mild	Moderate	Severe
1) Fatigue:	☐	☐	☐	☐
2) Mood Changes:	☐	☐	☐	☐
Irritability				
Anxiety / Nervousness				
Depression				
3) Decreased Mental Ability:	☐	☐	☐	☐
Memory Loss				
Confusion				
Loss of Focus				
4) Hot Flashes / Night Sweats	☐	☐	☐	☐
5) Weight Gain:	☐	☐	☐	☐
Bloating				
Excessive Belly Fat				
Inability to Lose Weight				
6) Decreased Sex Drive:	☐	☐	☐	☐
Vaginal Dryness				
7) Sleep Problems:	☐	☐	☐	☐
Can't Stay Asleep				
Can't Fall Asleep				
8) Cold Hands & Feet / Always Cold	☐	☐	☐	☐
9) Hair Loss / Breakage	☐	☐	☐	☐
10) Dry Wrinkled Skin	☐	☐	☐	☐

FAMILY HISTORY (please check Box)	NO	YES
Heart Disease	☐	☐
Diabetes	☐	☐
Osteoporosis	☐	☐
Alzheimer's Disease	☐	☐
Breast Cancer	☐	☐

Thank you for choosing Renove Medical Spa. Our primary mission is to deliver the best and most comprehensive aesthetic care available. An important part of the mission is making the cost of optimal care as easy and manageable for our patients as possible by offering several payment options.

Payment Options:

You can choose from:

- Cash, Visa@, MasterCard@, American Express@ or Discover Card@
- Convenient Monthly Payment Options! from Care Credit Healthcare Credit Card o NO Interest if Paid in Full within 6 Months• o Allow you to pay over time
- No annual fees or pre-payment penalties

Please note: Renove Medical Spa requires payment prior to the completion of your treatment. If you choose to discontinue care before treatment is complete, you will receive a refund less the cost of care received.

No refunds will be given once the treatment has been completed.

When booking an extensive treatment in advance we require 50% of the total cost down to hold as a guarantee for your appointment as we will be ordering or holding product specifically for you and your treatment.

A fee of $50 is charged for patients who miss or cancel more than 2 times in a calendar year without 24-hour notice.

Renove Medical Spa charges $25 for returned checks.

If you have any questions, please do not hesitate to ask. We are here to help you get the quality care you want or need.

_____

Patient, Parent or Guardian Signature Date

_____

Patient Name (Please Print)

Photograph / Media Consent Form

1, _____

(Print Name)

Please circle which option you voluntarily consent to.

I. I consent to the use of photographs and/or video footage for use on the Renove Medical Spa's website, social media accounts and/or any future advertising mediums and am okay with having my identity shown.

Il. I consent to the use of photographs and/or video footage for use on Renove Medical Spa's website, social media accounts and/or any future advertising mediums but wish to have my identity concealed by use of angles and/or a white bar across my eyes.

Ill. I do not wish to have photographs or video of myself of the Renove Medical Spa's website, social media and/or any future advertising mediums.

IV. I consent to Renove Medical Spa sharing my cell phone number and information with CMA in order for them to text me approximately once every 3 months to gain information about my results in an attempt to provide the best treatments and results moving forward.

_____

Signature

_____

Date

FOR OFFICE USE ONLY

Name:_____ DOB:_____ DOC:_____

PHYSICIANS NOTES

Concerns: _____

Face: _____

_____

_____

_____

Body:

_____

_____

_____

_____

_____

PHYSICIAN'S RECOMMENDED TREATMENT(S):

_____

_____

_____

_____

_____

Pricing:

_____

_____

FOR OFFICE USE ONLY

Name:_____ DOB:_____ DOC:_____

OFFICE NOTES: