Reflect Medical & Cosmetic Center, LLC

Patient Information: (Please complete using your name as listed on your insurance card. **PRINT CLEARLY**)

First Name: ____________ MI: ____________ Last Name: ____________

Date of Birth: ____________ SS#: ____________ Sex: M F

Address: ____________ Apt: ____________ City: ____________

State: ________ Zip: ________ Home Phone: ________ Cell Phone: ____________

Work Phone: ____________

Marital Status: Single Married Divorced Domestic Partner Widow

Employer: ____________ Occupation: ____________

STUDENTS ONLY: (If over 18 years of age) Part-time student Full-time student

Under a new federal law, the following questions are now required:

- ☐ English
- ☐ Spanish
- ☐ Other ____________
- ☐ I'd rather not report

- ☐ Hispanic/Latino
- ☐ Not Hispanic/Latino
- ☐ I'd rather not report

- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ Hispanic Origin
- ☐ Native Hawaiian or Pacific Islander
- ☐ White
- ☐ Other ____________
- ☐ I'd rather not report

Email Address: ____________

Do you have any impairment? (Please circle): Visual Hearing Speech Learning Physical Language/Cultural NONE

Person Responsible for Payment:

First Name: ____________ Initial: ____________ Last Name: ____________

Address: ____________ Apt: ____________ City: ____________

State: ________ Zip: ________ Home Phone: ________ Cell Phone: ____________

Relationship to patient: ____________ Date of Birth: ____________ SS#: ____________

Insurance Information: (All patients must provide a copy of their insurance card and proper ID at **every** visit.)

Primary Insurance: ____________ Policy Holder Name: ____________

Policy ID#: ____________ Group#: ____________

Relationship to patient: ____________ Policy Holder's Date of Birth: ____________ Se x: M F

Policy Holder's Employer: ____________

Secondary Insurance: ____________ Policy Holder Name: ____________

Policy ID#: ____________ Group#: ____________

Relationship to patient: ____________ Policy Holder's Date of Birth: ____________ Sex: M F

Policy Holder's Employer: ____________

Who may we thank for referring you? ____________

Reflect Medical & Cosmetic Center, LLC

Pharmacy Name: ____ Town/Location: ________________________

Have you had any of the following conditions ?

Condition			Condition		
Alcoholism	Y	N	Ear Problems	Y	N
Allergies	Y	N	Eating Disorder	Y	N
Anemia	Y	N	Epilepsy/Seizure Disorder	Y	N
Anxiety Disorder	Y	N	Glaucoma	Y	N
Arthritis	Y	N	Gout	Y	N
Asthma	Y	N	Heart Disease	Y	N
AIDS/HIV	Y	N	Heart Problems	Y	N
Back Problems	Y	N	High Blood Pressure	Y	N
Bleeding Disorder	Y	N	High Cholesterol	Y	N
Blood Disease	Y	N	Hepatitis/Liver Disorder	Y	N
Cancer	Y	N	Kidney/Renal disease	Y	N
Crohn's/Colitis Disease	Y	N	Migraines	Y	N
Diabetes	Y	N	Stomach Problems	Y	N
Depression	Y	N	Skin Disorder	Y	N

Do you have any of the following?

Symptom			Symptom		
Abnormal bleeding	Y	N	Nose bleeds	Y	N
Abdominal Pain	Y	N	Swelling in hands/feet	Y	N
Cough	Y	N	Wheezing	Y	N
Depression	Y	N	Heart palpitations	Y	N
Fever Blisters	Y	N	Joint pain	Y	N
Fever	Y	N	Headache	Y	N
Fatigue	Y	N	Urinary symptoms	Y	N
Erectile dysfunction	Y	N	Recent weight gain	Y	N
Excessive Sweat	Y	N	Recent weight loss	Y	N
Itching	Y	N	Swollen glands	Y	N

Please identify any of the following that a family member may have had:

Condition			Condition		
Alcoholism	Y	N	Kidney Disease	Y	N
Aneurysm	Y	N	Lung Disease	Y	N
Diabetes	Y	N	Mental or Psychiatric Disorders	Y	N
Heart Disease	Y	N	Sarcoid	Y	N
Hepatitis/Liver Disease	Y	N	Stroke/TIA	Y	N
Joint Disorder	Y	N	Thyroid Disorder	Y	N

Do you have a "Living Will" or Advance Directives? Y N

Are you sexually active? Y N , #of partners past year_____

Do you prefer: Male Female Both

Have you ever smoked or vape? Y N When did you start smoking?_____ When did you quit smoking?___

Do you drink alcohol? Y N # Drinks per day: _____________

How much caffeine do you drink per day?_______________ Do you exercise? Y N

Name of current medication: **(Including Aspirin, Birth Control, Vitamins Etc.)**	**What are you taking this for?**
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________

Drug Allergies: ____

E-PRESCRIBE CONSENT FORM

E-Prescribe is defined by a physician's ability to electronically send an accurate, error free, and understandable prescription directly to a pharmacy. Congress has determined that the ability to electronically send prescriptions is an important element in improving the quality of patient care. E-Prescribe greatly reduces medication errors and enhances patient safety. The Medicare Modernization Act (MMA) 2003 listed standards that have to be included in an E-Prescribe program. These include:

- **Formulary and benefit transactions –** gives the prescriber information about which drugs are covered by the drug benefit plan.

- **Medication history transactions** – provides the physician with information about medications the patient is already taking to minimize the number of adverse drug events.

By signing this consent form you are agreeing that Reflect Medical & Cosmetic Center, LLC can request and use your prescription medication history from other healthcare providers and/or third party pharmacy benefit payers for treatment purposes.

Understanding all of the above, I hereby provide informed consent to Reflect Medical & Cosmetic Center, LLC to enroll me in the E-Prescribe program.

Consent Accepted:

Patient Name (Print) ____

Signature: ____ Date:_______________

Relationship to Patient: ____________________________________