Name:____

Date of birth:____________________________________

Home town and zip:________________________________

Email:____

Phone:____

Allergies:_______________________________________

Medications within the past 7 days:____

Referred by:_____________________________________

Medical History: please CIRCLE all that apply:

Current Pregnancy	**Bleeding issues/disorder**
Heart issues	**Oral Herpes/cold sores**
High or low Blood Pressure	**Dermatology issues**
Breathing issues	**Trouble swallowing**
Diabetes	**Fainting or seizures**

recent or pending DENTAL work

AUTOTIMMUNE issues: _______________________________

If NONE, please circle: NONE

Have you ever had head, neck or facial surgery? Yes No

If you answered YES to any medical history or surgery

questions or have any other significant health issues, please list below:

In case of emergency please contact:

___________________________ phone:____________________

The information I have provided is complete and accurate:

____________________________________ date:___________

I have received or been offered a copy of Refine By Farrell's office privacy policies as pertaining to HIPPA: please sign below

___________________________ date:____________________