Bodies by Atun
15591 Creek Bend Dr. Suite 100
Sugar Land, TX 77478
P: (281)232-6700 F: (281)232-4545

Patient Profile

Patient Name: _____ Date: _____

D.O.B: _____/_____/_____ Age: _____ Gender: ☐ Female ☐ Male

Marital Status: S M D W Social Security #: _____ Driver License #: _____

Patient Contact Information

Address: _____

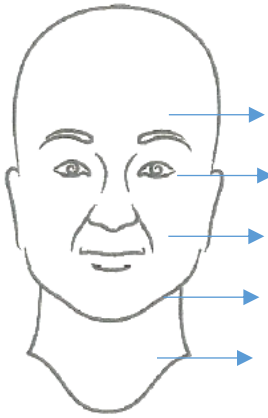
City: _____ State: _____ Zip Code: _____

Email: _____

Home Phone Number: _____ Mobile Phone Number: _____

Who should we contact in case of an emergency? Name: _____ P: _____

Tell Us What Matters Most to You (Check all that apply)



◯ Skin
◯ Brow/Forehead
◯ Eyes: Upper / Lower
◯ Nasal Labial Folds
◯ Jaw Line
◯ Neck

◯ Breast Enhancement
◯ Tummy Tuck
◯ Liposuction
◯ Fat Injections
◯ Brazilian Butt Lift
◯ Nonsurgical Options

Reason for appointment today: _____

Who referred you? _____

Agree and Acknowledge

I authorize Bodies by Atun to contact me or leave medical information pertaining to my care via the following methods:

☐ Home phone and/or voicemail ☐ Cell phone and/or voicemail ☐ No authorization

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Medical History

Patient Name: _____ Date: _____

Please respond to the following questions:

Breast Cancer?	☐ Yes	☐ No
Are you currently pregnant?	☐ Yes	☐ No
Are you currently undergoing radiation therapy or chemotherapy?	☐ Yes	☐ No
Have you ever had a connective tissue disorder?	☐ Yes	☐ No
Have you had surgery of the face or neck within the previous 6 months?	☐ Yes	☐ No
Oxygen dependent COPD or severe asthma?	☐ Yes	☐ No
Bleeding Disorder?	☐ Yes	☐ No
Abnormal Scarring?	☐ Yes	☐ No
Reaction to latex?	☐ Yes	☐ No
Lidocaine allergy?	☐ Yes	☐ No
Epinephrine sensitivity?	☐ Yes	☐ No
Currently taking Aspirin, Coumadin, Plavix, Pradaxa or any blood thinner?	☐ Yes	☐ No
Brain aneurysm or brain shunt?	☐ Yes	☐ No
Prior parotidectomy (salivary gland removal)?	☐ Yes	☐ No
Obstructive sleep apnea?	☐ Yes	☐ No
Do you have Restless Leg Syndrome?	☐ Yes	☐ No
HIV/AIDS?	☐ Yes	☐ No
Kidney Failure?	☐ Yes	☐ No
Liver insufficiency, cirrhosis or active hepatitis?	☐ Yes	☐ No
Blood clots or Pulmonary Embolism?	☐ Yes	☐ No
Diabetes that requires medication?	☐ Yes	☐ No
High Blood Pressure (hypertension)?	☐ Yes	☐ No
Melanoma?	☐ Yes	☐ No
Have you ever had an aortic aneurysm?	☐ Yes	☐ No
Angina or chest pain with exercise?	☐ Yes	☐ No
Angioplasty and/or stent placement?	☐ Yes	☐ No
Have you had a heart attack?	☐ Yes	☐ No
Do you have a pacemaker or AICD?	☐ Yes	☐ No
Heart Catheterization/ stress test? ☐ Normal ☐ Abnormal Date: _____	☐ Yes	☐ No
Have you ever had a stroke or TIA?	☐ Yes	☐ No
Are you a current smoker?	☐ Yes	☐ No
Severe dry eyes?	☐ Yes	☐ No
Limited neck mobility?	☐ Yes	☐ No
Anemia?	☐ Yes	☐ No
Depression?	☐ Yes	☐ No
Thyroids Disease?	☐ Yes	☐ No
Lupus?	☐ Yes	☐ No
Blood Transfusion?	☐ Yes	☐ No
Seizures?	☐ Yes	☐ No
Have you taken the medication Accutane within the past 12 months?	☐ Yes	☐ No

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Family Physician: _____ P: _____

May we contact your physician(s) to obtain a medical clearance if necessary? ☐ Yes ☐ No

Pharmacy: _____ P: _____

PLEASE LIST ANY SURGERIES YOU HAVE HAD:

_____

_____

_____

What Medications or Supplements (prescribed and non-prescribed) are you **currently taking?**

Medication:	**Dosage & Frequency:**

PLEASE LIST ANY MEDICATIONS THAT YOU ARE **ALLERGIC** TO AND DESCRIBE THE REACTION, IF ANY:

A little bit more about you

WOMEN ONLY

Date of last Mammogram: _____ Do you do self-breast examinations? ☐ Yes ☐ No
Did you breast feed? ☐ Yes ☐ No Have you had a breast lump or discharge? ☐ Yes ☐ No

Last Menstrual Cycle _____ Bra size _____ Weight _____ Height _____

PHOTOGRAPH CONSENT: We will routinely take photographs to document treatment results, before and after. Occasionally, we might use the image for teaching. We will not use these photos for advertising unless you give Bodies by Atun permission. If so, please initial below.

_____I **GIVE** Bodies by Atun consent to use my photographs and voice testimonial quotes for all advertising and marketing purposes so long as my name and age is not disclosed.

_____ I **DO NOT** give Bodies by Atun permission or consent for advertising. I understand that these photographs are the property of the Bodies by Atun and will be maintained as part of my medical chart.

I certify that I have listed all my current medications, allergies, hospitalizations, medical conditions and previous surgeries to the best of my knowledge and ability:

Patient Name: _____ Date: _____

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Insurance Information

The insurance form does not apply to cosmetic patients

Patient Name: _____ Date: _____

D.O.B: _____/_____/_____ Age: _____ Social Security: _____

Gender: ☐ Female ☐ Male Marital Status: S M D W Driver License #: _____

Patient Contact Information

Address:

_____

_____

Home Phone Number: _____ Mobile Phone Number: _____

Insurance Information (No insurance is required for cosmetic patients)

PRIMARY INSURANCE HOLDER:

PRIMARY INSURANCE:	
POLICY HOLDER NAME	
POLICY HOLDER D.O. B	
POLICY HOLDER SOCIAL SECURITY #	
MEMBER ID #	
GROUP #	

SECONDARY:

SECONDARY INSURANCE:	
POLICY HOLDER NAME	
POLICY HOLDER D.O. B	
POLICY HOLDER SOCIAL SECURITY #	
MEMBER ID #	
GROUP #	