



New Patient Intake Form

Please complete this form to the best of your ability. All information will remain confidential.

Personal Information

- **Full Name:** _____
 - **Date of Birth (MM/DD/YYYY):** _____
 - **Gender:** _____
 - **Address:** _____
 - **City:** _____ **State:** _____ **ZIP Code:** _____
 - **Cell Phone:** _____
 - **Email Address:** _____
 - **Social Security Number:** _____
(Used solely for identity verification when ordering medications)
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Emergency Contact

- **Name:** _____
 - **Relationship to Patient** _____
 - **Phone Number:** _____
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Reason for Visit

- **Primary reason for your visit:**

 - **Do you have any specific concerns or symptoms?**

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I am interested in discussing the following treatments or services:

(Please check all that apply)

Anti-Aging & Regenerative Medicine

- Hormone Replacement Therapy
- Peptide Therapy
- NAD+ Therapy
- Joint, Tendon, Ligament, or Muscle Pain Relief
- PRP Orthopedic Injections
- Fatigue Solutions
- IV Nutritional Therapy
- Insomnia Management
- Mood and Memory Support
- Muscle Mass Improvement

Weight Loss Programs

- GLP-1 RA Medications
- hCG Diet
- Nutrition Counseling (with Registered Dietitian)
- Exercise Evaluation and Guidance
- Online Cognitive Behavioral Therapy Resources

Aesthetic Treatments

- Neurotoxins (Botox, Letybo, Xeomin, Dysport)
- Navaclick (Painless Injections)
- Dermal Fillers (Face & Body)
- Lip Filler Injections
- Biostimulant Fillers (Radiesse, Sculptra)
- Body Sculpting (T-Shape 2, Fillers, Cellulite Cannula)
- Scar Reduction
- PDO Threads (Scar and Collagen Treatment)
- PDO Thread Face Lift
- Vampire Facial (PRP & Microneedling)
- Microneedling (with or without Exosomes, PDRN)
- Hair Restoration (Medications, PDO Threads, PRP)
- Mesotherapy (Targeted Fat Reduction)

- Kybella (Double Chin Treatment)
 - Sclerotherapy (Spider/Varicose Vein Treatment)
 - Laser Hair Removal
 - Laser Tattoo Removal
 - ProNox (Pain Management During Procedures)
 - Skin Lesion Removal (Skin Tags, Moles)
 - Ablative Skin Removal (Blepharoplasty)
 - Ablative Skin Tightening
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Referral Information

- **How did you hear about us?**

- **Who may we thank for the referral?**

Aesthetic Clinic Photo Policy & Consent

Your Privacy Is Our Priority

To ensure the highest standard of care and transparency, we ask for your consent to take and use photos as part of your treatment.

Why We Take Photos:

- To track treatment progress
- For accurate treatment planning and outcomes

How We Store Photos:

- Securely stored in your confidential medical file
- Access limited to authorized clinical staff

Optional Uses (With Consent):

- Education: For training purposes
- Marketing: Website, social media, brochures, etc.
You must provide written consent before any photo is used for non-medical purposes.

Your Rights:

- You may decline consent for any non-medical use
 - Declining does not affect your care
 - If you consent and change your mind, you may withdraw it in writing at any time
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Photo Consent Form

Client Name: _____

Date of Birth: _____

Please check the applicable boxes:


- I consent to the use of my photos for **educational** purposes
- I consent to the use of my photos for **promotional** purposes
- I do **not** consent to the use of my photos for any purpose other than medical documentation

Signature: _____

Date: _____

Contact Information

If you have any questions or concerns regarding this form or your care, please contact us:

 **Phone:** 985-214-4795

 **Email:** deborah@austpain.com

We are committed to protecting your privacy and ensuring your comfort at every step of your care.