Third Circle Medical
PATIENT REGISTRATION FORM

Today's Date:	**Primary Care Provider:**

PATIENT INFORMATION

Patient's Last name:	**First:**	**Middle:**	**Marital status:**

Is this your legal name? ☑ Yes ☐ No	If not, what is your legal name?	Former name:	**Birth date:**	**Age**:	**Sex:** ☐ M ☐ F

Address:	**City:**	**State:**	**Zip:**

Social Security no.:	**Home phone no.:**	**Cell phone no.:**
Your Email:	**Your Employer:**	**Employer phone no.:**

Chose clinic because/referred to clinic by (Please choose one option):

☑ [Doctor's name]

☐ Friend

IN CASE OF EMERGENCY WHO WOULD YOU LIKE US TO CONTACT :

Name of local friend or relative:	Relationship to patient:	Home phone no.:	Work phone no.:

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

Patient or Guardian Signature

Date

Third Circle Medical
MEDICAL HISTORY INFORMATION SHEET

NAME: _____ AGE: _____ TODAY'S DATE: _____

DATE OF BIRTH: (m/d/y) _____/_____/_____ HEIGHT: _____ ft _____ inches WEIGHT: _____ lbs

REASON FOR TODAY'S EXAM: _____

HISTORY:

Past Surgical History: Surgery	Date	Past Medical History: Condition	Date

HISTORY OF SERIOUS INJURIES OR ILLNESSES: ☐ YES ☐ NO If yes, please describe: _____

_____

COVID Vaccine: ☐ YES ☐ NO If yes, which one: _____ Booster**:** ☐ YES ☐ NO

Family History: (check all that apply and relationship to patient)

☐ Heart Attack_____ ☐ Cancer _____ ☐ Colon Problems _____☐ Diabetes _____

☐ Blood Pressure _____ ☐ Other: _____

☐ None

SOCIAL HISTORY:

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Children How Many? _____

Tobacco Use: ☐ Never ☐ In the Past ☐ Currently: Type? _____ How much? _____ How long? _____

Alcohol Use: ☐ Daily ☐ Occasional ☐ Never Other substance use or abuse? ☐ Yes ☐ No Type: _____

Do you have allergies? ☐ Yes ☐ No ☐ Food ☐ Drug ☐ Latex ☐ Other: _____

ALLERGEN	REACTION

Medications: List of Medications (including over-the-counter medications)

(If you have list, we can make a copy)

Medications	Dosage	Frequency

Your Pharmacy Name and Address: _____

Third Circle Medical

Cenchrea Lanier, MSN, ANP-BC,

1609 Rosewood Drive

Columbia TN 38401

Phone: 855-222-7938

Date: _____

Name: _____ Date of Birth: _____

CONSENT TO BOTULINUM TOXIN A (Botox®) TREATMENT

Botulinum toxin A neurotoxin produced by the bacterium Clostridium A can relax the muscles on areas of the face which cause wrinkles associated with facial expressions. Treatment with Botox® can cause our facial expression lines or wrinkles to essentially disappear. Areas most frequently treated are the glabellar area of frown lines, located between the eyes, crows feet (lateral areas of the eyes), and forehead wrinkles. Botox® is diluted to a controlled solution and when injected into the muscles with a very thin needle, it is almost painless. Clients may feel a slight burning sensation while the solution is being injected. The procedure takes about 15-20 minutes and the results last 3-5 months. With repeated treatments, the results may last longer.

Initial _____

RISKS AND COMPLICATIONS

It has been explained to me that there are certain inherent and potential risks and side effects in any invasive procedure and in this specific instance, such risks include, but are not limited to:

1. Post-treatment discomfort, swelling, redness, and bruising
2. Post-treatment bacterial, viral, and/or fungal infection requiring further treatment
3. Allergic reaction
4. Minor temporary drooping of the eyelid(s) in approximately 2% of injections that may last 2-3 weeks.
5. Occasional numbness of the forehead lasting up to 2-3 weeks
6. Transient headache
7. Possible occurrence of flu-like symptoms **Initial_____**

PHOTOGRAPHS

I authorize the taking of clinical photographs and their use for scientific purposes, both in publications and presentations. I understand that my identity will be protected. **Initial _____**

PREGNANCY, ALLERGIES, & NEUROLOGIC DISEASE

To my knowledge, I do not have any significant neurological disease, nor any allergies to the toxin ingredients or to human albumin. I am not currently pregnant. **Initial _____**

PAYMENT

I understand that this procedure is a cosmetic procedure and that payment is my responsibility and expected at the time of service. My insurance will not be billed. **Initial _____**

RESULTS

I am aware that when small amounts of purified botulinum toxin A (Botox®) are injected into a muscle, it causes weakness or paralysis of the muscle. This appears within 3-10 days of the injection and usually lasts 3-5 months, but can be shorter or longer. In a very small number of individuals, the injection does not work as satisfactorily or for as long as usual. I understand that I will not be able to "frown" while the injection is effective, but that this will reverse after a period of months, at which time, retreatment is appropriate. I understand that I must stay in erect posture and that I must not manipulate the area of the injection for four (4) hours after I have the injection. **Initial _____**

I voluntarily consent to treatment with Botox® injected for the condition known as facial dynamic wrinkles. The procedure has been explained to me. I have also read the above information and I understand it. My questions have been answered satisfactorily. I accept the risks and complications of the procedure.

_____ _____

Client Signature **Date**

Third Circle Medical

Cenchrea Lanier, MSN, ANP-BC,

1609 Rosewood Drive
Columbia TN 38401
Phone: 855-222-7938

Dear Patient,

You are being provided this letter of acknowledgment because you have requested that your doctor visit today be coded as "self-pay" and that you receive a "self-pay cash discount". A self-pay cash discount is offered to patients who elect to pay for the service in full on the date of service and who ***will not be submitting the claim to an insurance carrier***. You have requested that this service be coded as self-pay cash discount because **(initial one):**

____ You have **no** health insurance
____ You have health insurance but you will **not** be billed and instead want to pay out of pocket.
____ Cosmetic Procedure (Botox, Sclerotherapy, PRP Facial, PRP Injections)
____ Other Service (includes IV Wellness Infusions)
____ Other (please explain):
_____

We want you to know what to expect so that you can make an informed decision. In order to accomplish this, by signing below you agree to the following:

- All fees for the self-pay cash discount service must be paid on the date of service.
- The self-pay cash discount amount covers only the professional services provided by your provider. You are financially responsible for all ancillary services, for example: laboratory, x-ray, or other services at Third Circle Medical not performed by your provider. You will receive a separate bill from the ancillary services.
- If you have insurance or other types of coverage, services today that are included in the "self-pay" cash discount will not likely be reimbursed by your carrier, or applied to your deductible. You may want to discuss this with your insurance carrier before agreeing to the self-pay cash discount.

By my signature below, I acknowledge that I have read and understand the above and have been given the opportunity to ask questions.

I confirm that I am the patient, or the patient's duly authorized representative.

Patient Signature _____ Date: _____

If signed by someone other than the patient, please specify relationship to the patient:
_____

Signature: _____ ID#_____ Date: _____ Time: _____

NOT PART OF THE LEGAL MEDICAL RECORD

Third Circle Medical
Cenchrea Lanier, MSN, ANP-BC,
1609 Rosewood Drive
Columbia TN 38401
Phone: 855-222-7938

BOTOX® AFTER CARE

1. DO NOT massage the BOTOX® treated areas for 4-6 hours.

2. DO NOT bend over for prayer (e.g., to tie shoes or pick up something from the floor), gym exercise for a night after BOTOX® treatment of the face.

3. LIMIT heavy physical activity, and lying down or sleeping for at least 4 hours after BOTOX® treatment of the face.

4. DO NOT rub area of injection, this may cause displacement of BOTOX®.

5. DO contract treated muscles for 2-4 hours immediately after a BOTOX® treatment. This promotes the uptake of BOTOX® by the receptor sites at the neuromuscular junctions.

6. DO return to office in 2 weeks to monitor progress. Results may not be seen for at least 10-14 days.

By my signature below, I acknowledge that I have read and understand the above and have been given the opportunity to ask questions.

I confirm that I am the patient, or the patient's duly authorized representative.

Patient Signature _____ Date: _____