
5765 S. Rainbow Blvd, Ste. 111
Las Vegas, NV 89118
P: 725-726-7914 | F: 504-370-5627

## Aesthetics Patient Intake Form

Full Name: _____

Date of Birth: __/__/____

Social Security #_____-_____-_____

Gender: ☐ Male ☐ Female ☐ Other

Address: _____

City: _____

State: _____

Zip Code: _____

Phone Number: (___) ___-____

Email Address: _____

Emergency Contact: _____

Relationship: _____

Phone Number: (_____) _____-_____

***Insurance Information***

Primary Insurance: _____

Policy Number: _____

Group Number: _____

Subscriber's Name: _____

Subscriber's Date of Birth: __/__/____

Relationship to Patient: _____

Do you have Secondary Insurance?

If Yes: _____

**Medical History**

Primary Care Physician: _____

Phone Number: (_____)_____-_____

Date of Last Physical Exam: ____/____/____

***Medical Conditions (Check all that apply)***

☐ Diabetes
☐ Hypertension
☐ Heart Disease
☐ Asthma
☐ COPD
☐ Cancer
☐ Stroke
☐ Arthritis
☐ Osteoporosis
☐ Thyroid Disorder
☐ Kidney Disease
☐ Liver Disease
☐ Seizures
☐ Depression
☐ Anxiety
☐ Other: _____

***Surgeries (Please list all surgeries and dates)***

1. _____ Date: __/__/____
2. _____ Date: __/__/____
3. _____ Date: __/__/____

***Allergies (Check all that apply)***

☐ No Known Allergies
☐ Medications: _____
☐ Foods: _____
☐ Environmental: _____
☐ Other: _____

***Family Medical History (Check all that apply)***

☐ Diabetes
☐ Hypertension
☐ Heart Disease
☐ Cancer
☐ Stroke
☐ Other: _____

***Social History***

Tobacco Use: ☐ Never ☐ Former ☐ Current
Alcohol Use: ☐ Never ☐ Socially ☐ Frequently
Drug Use: ☐ Never ☐ Former ☐ Current

Occupation: _____
Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed
Children: ☐ Yes ☐ No If yes, how many? _____

***Pharmacy Information***

Please provide the details of your preferred pharmacy. This information will help us send your prescriptions directly to your pharmacy for your convenience.

**Pharmacy Name:**_____

**Pharmacy Address:**_____

**City:**_____

**State:**_____

**Zip Code:**_____

**Pharmacy Phone Number:**_____

**Pharmacy Fax Number (if available):**_____

***Review of Systems (Check all that apply)***

**General:**
☐ Weight Loss
☐ Weight Gain
☐ Fatigue
☐ Fever

**Cardiovascular:**
☐ Chest Pain
☐ Palpitations
☐ Shortness of Breath

**Respiratory:**
☐ Cough
☐ Wheezing
☐ Shortness of Breath

**Gastrointestinal:**
☐ Nausea
☐ Vomiting
☐ Diarrhea
☐ Constipation

**Musculoskeletal:**
☐ Joint Pain
☐ Muscle Pain
☐ Back Pain

**Neurological:**
☐ Headaches
☐ Dizziness
☐ Numbness

**Psychiatric:**
☐ Depression
☐ Anxiety
☐ Insomnia

### *Medication List*

Please list all prescription medications, over-the-counter drugs, vitamins, supplements, and herbal remedies you are currently taking.

| Medication Name | Dosage (mg, units, etc.) | Frequency (daily, weekly, as needed, etc.) | Reason for Use | Prescribing Physician |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

## Allergies & Reactions

Do you have any allergies to medications?

☐ **No**

☐ **Yes** (If yes, please list below)

| Medication Name | Reaction (e.g., rash, swelling, anaphylaxis, nausea, etc.) |
|---|---|
| | |
| | |
| | |
| | |
| | |

## *Consent to Treatment in a Teaching Institution*

Welcome to NuThera. We are a teaching institution committed to providing high-quality care while training the next generation of healthcare professionals. This means that students, including Physician Assistant (PA) students, may assist in your treatment under the supervision of a licensed physician (MD) or physician assistant (PA).

---

**Supervision Details:**

- All student activities are supervised by a licensed MD or PA.
- The supervising MD or PA is on-site and readily available to provide guidance and support.

**Patient Consent:** By signing this form, you acknowledge and consent to the involvement of students in your care. If you do not wish to be treated by a student, please indicate your preference below.

---

**Consent Agreement:**

I consent to receive treatment from students under the supervision of a licensed MD or PA.

Signature_____ Date_____/_____/_____

---

**Non-Consent Agreement:**

I do not consent to be treated by students and wish to be seen only by trained kinesiotherapist, PT, chiropractor, PA, or MD.

Signature_____ Date_____/_____/_____

Thank you for your understanding and cooperation. Your decision will not affect the quality of care you receive at NuThera.

***Consent Form for Photographic Documentation and Use of Images Patient***

Patient Name:_____Date of Birth:_____/_____/_____

Purpose of Photographic Documentation: Your healthcare provider has recommended starting GLP-1 therapy (e.g., semaglutide or tirzepatide) for your medical condition. As part of your treatment plan, we would like to take baseline and follow-up photographs to document your physical appearance and monitor your progress.

**Photographic Documentation Consent:**

I,_____ (patient's name), consent to having my photographs taken by the healthcare provider or designated medical staff for the purpose of

documenting my physical appearance before and during my GLP-1 therapy. These photographs will include images of my face and body from the front, side, and back views.

- I understand that these photographs will be used solely for medical purposes, including treatment planning, monitoring progress, and inclusion in my medical record.
- I understand that these photographs will be stored securely and will be accessible only to authorized medical personnel involved in my care
- I understand that these photographs will remain confidential and will not be shared with third parties without my explicit consent, except as required by law.

**Consent for Use of Photographs for Educational and Promotional Purposes:** In addition to the medical use of my photographs, I consent to the use of these images for educational and promotional purposes. This may include, but is not limited to, medical presentations, educational publications, marketing materials, and social media.

- I understand that my identity will be protected and my photographs will be anonymized to ensure that I cannot be personally identified.
- I understand that I will not receive any compensation for the use of my photographs.
- I understand that I can withdraw my consent for the use of my photographs for educational and promotional purposes at any time by providing written notice to the healthcare provider.

**Consent Acknowledgement:** By signing below, I acknowledge that I have read and understand the information provided in this consent form. I have had the opportunity to ask questions, and all my questions have been answered to my satisfaction. I voluntarily consent to the photographic documentation and the use of my photographs as described above.

Patient Signature_____Date:_____/_____/_____

**Do Not Consent for Use of Photographs for Educational and Promotional Purposes:**

- I do not consent to the use of my photographs for educational and promotional purposes. My photographs will be used solely for medical purposes and will remain confidential.

**I Do Not Consent to Photographic Documentation:**

I,_____(patient's name), do not consent to having my photographs taken by the healthcare provider or designated medical staff for any purpose.

Patient Signature_____Date:_____/_____/_____

**Withdrawal of Consent:** If you wish to withdraw your consent for the use of your photographs for educational and promotional purposes, please contact your healthcare provider in writing.

***CONSENT FORM FOR SMS TEXT MESSAGING***

Patient Name:_____Date of Birth:_____/_____/_____

I,_____ (Patient'sName), hereby consent to the use of SMS text messaging as a method of communication for administrative and clinical purposes by NuThera, medical practice. I understand that

1. SMS text messaging is not a completely secure medium and privacy cannot be ensured. NuThera, medical practice is not responsible for any loss, harm, or damage that may arise from this method of communication.
2. I may revoke this consent at any time by providing written notice to NuThera, medical practice.
3. Message and data rates may apply depending on my mobile carrier and plan.
4. I can opt out of SMS text messaging at any time by replying STOP to any received message.
5. The following types of information may be communicated via SMS text messages: appointment reminders, billing information, test results, and general health reminder information.

**By signing this form. I acknowledge that I have read, understood, and agree to the above terms.**

Patient Signature_____Date:_____/_____/_____

### *Consent for Treatment*

I hereby consent to the evaluation and treatment of my medical condition by the healthcare providers at this facility. I understand that this may include diagnostic tests, procedures, and medications as deemed necessary.

Patient Signature_____Date:_____/_____/_____

**If the patient is underage, the following section must be completed by an appropriate representative:**

**Parent or Guardian Signature:_____**