Tru Luxe Medspa and Wellness, L.L.C.

Dear Valued Patient,

On behalf of the providers and staff at Tru Luxe Medspa and Wellness, L.L.C., we want to welcome you to our practice and thank you for choosing a Tru Luxe to care for you and/or your loved ones.

At Tru Luxe, our provider puts her patients and client's needs first. We are committed to providing you and your family with the highest-quality care and exceptional customer service. Our provider is board certified and committed to promoting good health and guiding patients and clients toward a healthy lifestyle.

Paulette Senegal, APRN, FNP-C, is an Advanced Practice Registered Nurse and a board-certified Family Nurse Practitioner who specializes in Hormone Replacement Therapy, Weight Loss Therapy, IV Hydration Therapy and Therapeutic Neurotoxins (i.e., Botox, Dysport, Fillers). After spending several years working in the hospital setting, Paulette developed a newfound desire to not just treat people who were ill, but to provide an opportunity to keep people healthy in the first place. With that mission in mind, Paulette founded Tru Luxe Medspa and Wellness which has provided her the platform to follow her passion in creating and maintaining a healthy you!

Paulette V. Senegal

Sincerely,
Paulette Senegal, APRN, FNP-C
Tru Luxe Medspa and Wellness, L.L.C.
5529 Louetta RD. Ste. A7
Spring, Texas 77379
346.296.0520

Tru Luxe Medspa and Wellness, L.L.C.

PATIENT INFORMATION

Patient's Name (First, Middle, Last): _____

Address: _____

City:_____ State:_____ Zip Code: _____ Email: _____

Main Contact#: _____ Alternate#:_____ Work#: _____

Date of Birth: _____/_____/_____ Sex: ○ Male ○ Female SS# (optional): _____

Marital Status : ○ Single ○ Married ○ Divorced ○ Widowed Occupation: _____

Patient Referred By: _____ Spouse's Name: _____

Spouse's Date of Birth: _____/_____/_____ Main Contact#: _____ Alternate#: _____

Emergency Contact:_____ Relationship: _____ Phone#: _____

Primary Care Physician: _____ Phone#:_____

Referring Physician: _____ Phone#:_____

Other Patient Information

Which racial category does the patient most closely identify with?

○ African American ○ Asian ○ Caucasian ○ Hispanic

○ Native American ○ Native Hawaiian ○ Pacific Islander ○ Other: _____(Please Specify)

Ethnicity: What is the patient's ethnicity? ○ Hispanic or Latino ○ Not Hispanic or Latino

What is the patient's language of preference? ○ English ○ Spanish ○ Other: _____(Please Specify)

Payment Information

FINANCIAL POLICY

Tru Luxe Medspa and Wellness, L.L.C. recognizes the need for a clear understanding between patient and medical provider regarding protected health information and financial arrangements for healthcare. The following information is provided to avoid any misunderstanding concerning protected health information and payment for professional services.

PAYMENT: Tru Luxe is a Self-pay practice and payment is expected at the time of service. If you have any questions or need any clarity on our payment policy, we ask that you inquire prior to services being rendered. We require an advance payment for professional services.

Patient's Initials:_____

Complete – Only if Patient is a Minor

Parent/Guardian Name: _____ Relationship: _____

Parent/Guardian Name: _____ Relationship: _____

Siblings:_____ DOB: _____/_____/_____ Other Siblings:_____ DOB: _____/_____/_____

Tru Luxe Medspa and Wellness, L.L.C.

GENERAL CONSENT FORM

Patient Name: _____ **Date of Birth:** _____ /_____ /_____

Consent for Treatment. I consent for Tru Luxe to administer treatments, tests and/or diagnostic tests to treat my/the patient's injury/illness or condition on an outpatient basis. I acknowledge there is no guarantee as to the outcome of any treatment I/the patient receives. In compliance with state law, if another individual is accidentally exposed to my/the patient's blood or body fluids (BBF); or if a medical or surgical procedure could expose another individual to my/the patient's BBF, Tru Luxe may have such BBF tested for human immunodeficiency infection (HIV/AIDS) at Tru Luxe's expense.

Patient Initials: _____

Electronic Prescription. I understand that Tru Luxe utilizes electronic prescribing technology and participates with Practice Fusion. Practice Fusion operates the Pharmacy Health Information Exchange, which facilitates the electronic transmission of prescription information between providers and pharmacists. Practice Fusion also provides prescription data on any medications, known as medication history, which are prescribed to me/the patient.

Patient Initials: _____

Phone Calls. By providing contact information, I authorize Tru Luxe and it's staff to use the contact information I have provided to communicate with me and to place calls to my home/cellular/employment telephone; leave voice or text messages; and use pre-recorded/artificial/voice messages and/or auto-dialing devices in connection with any communication to me.

Patient Initials: _____

Involvement of Others in Care. I authorize Tru Luxe to discuss my/the patient's care and medical needs with the following persons:

Name	Date of Birth (for identification)	Relationship	Phone

☐ I DO NOT wish to add an additional contact to discuss my/the patient's needs. **Patient Initials:** _____

May We Contact You By Phone and Leave a Message About Your Care?

Primary Phone #: _____ Secondary Phone #: _____

☐ Leave message with contact number only.
☐ Leave message with detailed information.
☐ Do not leave message.

☐ Leave message with contact number only.
☐ Leave message with detailed information.
☐ Do not leave message.

Patient Financial Policy

I acknowledge receipt of the "Patient Financial Policy." **Patient Initials:** _____

Notice of Privacy Practices

I acknowledge receipt of the "Notice of Privacy Practices." **Patient Initials:** _____

Minor Patient Photograph (when applicable)

I consent for Tru Luxe to photograph the minor patient for identification purposes only. **Patient Initials:** _____

_____
Print Name of Patient or Personal Representative

_____ _____
Signature of Patient or Personal Representative Date

Tru Luxe Medspa and Wellness L.L.C

NEW PATIENT MEDICAL HISTORY FORM

DATE TODAY: _____

NAME: _____ _____ _____ **D.O.B.** ____/____/____
LAST FIRST M.I.

OCCUPATION: _____

REASON FOR VISIT TODAY: _____

_____

ALLERGIES (Include medications, foods, xray dyes) or ☐ **NONE KNOWN**

Name of allergen	Type of reaction	Approximate date
1		
2		
3		

CURRENT MEDICATIONS (Include prescription, over the counter, and herbal medications. Attach extra sheet if necessary) or ☐ **NONE**

Name of medication	Dose (mg)	How often taken	Reason for taking medication	Physician prescribing
1				
2				
3				

PHARMACY (list pharmacy most frequently used for prescriptions)

Name: _____ Phone #: _____ Fax #: _____

Address: _____ City: _____ State/Zip: _____

PREVIOUS HOSPITALIZATIONS (Include all non surgical hospitalizations. Attach extra sheet if necessary) or ☐ **NONE**

Reasons for hospital stay	Date (approximate)	Hospital or city if known
1		
2		
3		

SURGERIES (Include all surgery in your lifetime. Attach extra sheet if necessary) or ☐ **NONE**

Type of surgery	Date (approximate)	Hospital or city if known
1		
2		
3		

OB/GYN HISTORY: No. of Pregnancies: _____ No. of Deliveries: _____ Last Menstrual cycle: _____

TOBACCO HISTORY

Are you an active cigarette smoker? ☐ Yes ☐ No

Have you ever been a cigarette smoker? ☐ Yes ☐ No

If yes, I smoked an average of _____ packs/day for _____ years. I quit in _____(year)

Do you use other tobacco products? ☐ Yes ☐ No

If yes, please specify _____

ALCOHOL AND DRUG HISTORY

Have you ever been diagnosed with alcoholism? ☐ Yes ☐ No

Do you currently drink alcohol regularly? ☐ Yes, currently ☐ Never/rarely

If yes, approximately how many drinks per week (beer, wine, or liquor)_____

Have you ever used intravenous drugs? ☐ Yes ☐ No

FAMILY HISTORY

Is there a history in your family of:	Yes	No	Affected relative(s)
Heart attack			
Diabetes			
Prostate cancer			
Kidney cancer			
Kidney stones			
Other significant disease			

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NEW PATIENT MEDICAL HISTORY FORM

DATE TODAY: _____

NAME: _____ LAST _____ FIRST _____ M.I. **D.O.B.** ____/____/_____

Please check "X" the complaint(s) or ailment(s) that apply to you. If you are unsure, place a question mark (?)

General	Fatigue / Tired	☐Yes	☐No
	Fever / Chills	☐Yes	☐No
	Headache	☐Yes	☐No
	Weight Loss	☐Yes	☐No
	Weight Gain	☐Yes	☐No
	Other: _____		
Eyes	Difficulty Seeing	☐Yes	☐No
	Other: _____		
Head Ears Nose Throat	Dry Mouth	☐Yes	☐No
	Hearing Problems	☐Yes	☐No
	Hoarseness	☐Yes	☐No
	Lumps/Swelling in Neck	☐Yes	☐No
	Sore Throat	☐Yes	☐No
	Trouble Swallowing	☐Yes	☐No
	Other: _____		
Cardiac (Heart)	Chest Pain	☐Yes	☐No
	Irregular Heart Beat	☐Yes	☐No
	Pain with Walking	☐Yes	☐No
	Shortness of Breath	☐Yes	☐No
	Swelling in Feet/Ankles	☐Yes	☐No
	Other: _____		
Neuro	Dizziness	☐Yes	☐No
	Fainting	☐Yes	☐No
	Headache	☐Yes	☐No
	Memory Loss	☐Yes	☐No
	Numbness	☐Yes	☐No
	Weakness	☐Yes	☐No
	Other: _____		
Respiratory	Cough	☐Yes	☐No
	Shortness of Breath	☐Yes	☐No
	Use of Inhalers	☐Yes	☐No
	Wheezing	☐Yes	☐No
	Other: _____		
Gastro-Intestinal	Abdominal Pain	☐Yes	☐No
	Blood in Stool	☐Yes	☐No
	Change in Bowel Habits	☐Yes	☐No
	Constipation	☐Yes	☐No
	Heartburn	☐Yes	☐No
	Loss of Appetite	☐Yes	☐No
	Nausea	☐Yes	☐No
	Vomiting	☐Yes	☐No
	Other: _____		
Males Only	Blood in Urine	☐Yes	☐No
	Difficulty Achieving Erection	☐Yes	☐No
	Foul Odor in Urine	☐Yes	☐No
	Pain in Testicles	☐Yes	☐No
	Trouble Urinating	☐Yes	☐No
	Other: _____		
Females Only	Breast Discomfort	☐Yes	☐No
	Irregular Bleeding	☐Yes	☐No
	Last Menstrual Cycle *Date:* _____		
	Painful Intercourse	☐Yes	☐No
	Post Menopausal Bleeding	☐Yes	☐No
	Trouble Urinating	☐Yes	☐No
	Vaginal Discharge	☐Yes	☐No
Musculoskeletal			
	Back Pain	☐Yes	☐No
	Joint Pain	☐Yes	☐No
	Muscle Pain	☐Yes	☐No
	Swelling	☐Yes	☐No
	Other: _____		
Skin Hair Nails	Bruising	☐Yes	☐No
	Hair Loss	☐Yes	☐No
	Nail Problems	☐Yes	☐No
	Rash	☐Yes	☐No
	Skin Changes	☐Yes	☐No
	Other: _____		
Mental Health	Anxiety	☐Yes	☐No
	Depression	☐Yes	☐No
	Difficulty Sleeping/Concentrating	☐Yes	☐No
	History of Physical/Mental Abuse	☐Yes	☐No
	Mood Swings	☐Yes	☐No
	Stress	☐Yes	☐No
	Suicidal	☐Yes	☐No
	Other: _____		

Recent Tests/ Health Maintenance (Give month/year of last exam in right column. Check left column if date is estimated.)

- ☐ Bone Density: _____
- ☐ Colonoscopy: _____
- ☐ Diabetic Foot Exam: _____
- ☐ Eye Exam: _____
- ☐ Mammogram: _____
- ☐ Pap Smear: _____
- ☐ Physical: _____
- ☐ PSA: _____
- ☐ Tetanus Shot: _____