



Patient Information (Please Print Legibly)

Patient Name _____
First Middle Last Nick Name

Address _____
Street & Apt # City State Zip

Home Phone () - Cell Phone () - E-mail _____

Work Phone () - Is it okay to contact you by phone? Yes No: _____

Age Birthdate / / SS# - - Sex Female Male

Marital Status Single Married to: Other: _____

Can we talk to spouse about your care: yes or no

Patient's Employer Occupation _____

Emergency Contact Relationship to Patient _____

Home Phone () - Work Phone () -

How did you hear about us? Reason for todays visit? _____

How soon are you wanting to have your surgery/procedure?

- ASAP 6-8 Weeks 6 Mths-Yr.

The following is a list of some of the various services we provide to our patients, as well as skin care problems we can treat. Please indicate below any area in which you may be interested in learning about.

These are the areas of concern for me:

Surgery of Interest:

- Leg Veins Dark Circles
Freckles Broken Facial Veins
Rough texture of skin Dryness
Enlarged Pores Oily Skin
Hair on face/body Sagging Skin
Exfoliation Acne
Brown spots Scarring
Sun Damage
Fine Lines and Wrinkles (Botox / Lasers)
Hyper Pigmentation (Uneven Skin Tone)
Deep Lines around nose and mouth (Wrinkle Fillers)

- Breast Augmentation / Breast Lift
Breast Reduction
Abdominoplasty (Tummy Tuck)
Liposuction /Lite Shape /LipoDissolve
Body Lift
Arm Reduction
Rhinoplasty (Nose Reshaping)
Blepharoplasty (Upper or Lower Eyes)
Facelift / Mini Facelift
Forehead Lift
Lip Enhancement
Otoplasty (Ear Pinning)

Ranking of concern:

Ranking of concern:

- 1.
2.
3.

- 1.
2.
3.

If time permits, would you be interested in seeing the Skincare Specialist today or at another time? Yes No



History and Physical
(Please Print Legibly)

Drug Allergies and Reactions _____

Other Allergies (i.e. latex, iodine, tape, skin sensitivity) _____

Present Medications (including diet pills, vitamins and herbal preparations)

Table with 4 columns: Medication, Times Per Day, Miligrams, Reason Prescribed

Previous Surgeries (please give year)

Table with 4 columns: Surgery, Year, Surgery, Year

Explain any reaction you have had to anesthesia _____

List any diseases that run in your family (i.e. cancer, heart disease, diabetes, etc.) _____

Check any of the following conditions you have:

- Arthritis, Anemia, Bleeding disorders, HIV / Hept, Peptic ulcer, Kidney disease, Poor circulation, Do you smoke?, Diabetes, Heart disease, Nervous condition, Liver disease, High blood pressure, Lung disease

Do you drink alcohol? No Yes: _____ 8oz Glasses per week or month (circle one)

Do you take aspirin, ibuprofen, Motrin, Nuprin, Ecotrin, or Advil on a regular basis? Yes No

How Often: _____ Per day, week or month (Circle one) Reason _____

Height _____ Weight _____

In order to establish optimal relations with our patients and avoid misunderstanding regarding our payment policies, our staff is trained to inform you of the financial polices of this office. PAYMENT IS EXPECTED FROM YOU FOR "YOUR PART" OF THE CHARGES. WE ACCEPT ALL MAJOR CREDIT CARDS AND CHECKS FOR YOUR CONVENIENCE. Your signature below indicates that you understand and accept this policy. Further, you acknowledge that if using a credit card or loan in someone else's name, we need written consent from cardholder and should the account fall behind at any point, you understand that any unpaid balance is your responsibility.

Signature of patient or legal guardian

Date