

## Patient Information

Name: \_\_\_\_\_

Today's Date: \_\_\_\_\_

Address: Home \_\_\_\_\_  
*Street City State Zip*

Business \_\_\_\_\_  
*Street City State Zip*

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

Phone Contact: \_\_\_\_\_

Sex: (M) (F) Marital Status: S, M, D, Sep, Widowed

SSN# \_\_\_\_\_

Occupation: \_\_\_\_\_

Employer: \_\_\_\_\_

How were you referred to us?  
\_\_\_\_\_

e-mail address: \_\_\_\_\_

Name(s) of family members who have been treated by our staff  
\_\_\_\_\_

Yes No Do you wish to receive our email newsletter?

Yes No Do you wish to receive our regular newsletter

### Insurance

[We will need a copy of your insurance card for our records.]

Primary Carrier:

Insurance Carrier \_\_\_\_\_ Number \_\_\_\_\_

Secondary Carrier:

Insurance Carrier \_\_\_\_\_ Number \_\_\_\_\_

Insured's Name \_\_\_\_\_

Insured's Name \_\_\_\_\_

Person responsible for bill \_\_\_\_\_

Person responsible for bill \_\_\_\_\_

### Medical History

Circle any of the following you have experienced:

Asthma	Arthritis	Venereal Disease	Other Blood Problems
Hay Fever	Arthritis therapy	AIDS / HIV	Substance abuse therapy
Nasal allergies	Steroid therapy	Frequent headache	Bouts of depression
Visual problems	Poor circulation	Excess Scarring	Nervous breakdown
Kidney trouble	Dizziness	Thyroid therapy	Psychiatric therapy
Bladder trouble	Convulsions	Frequent chest pain	Gall bladder trouble
Lung trouble	Skin infection	Paralysis	Stomach ulcers
Heart trouble	Skin irritation	Hormone therapy	Other stomach trouble
High blood pressure	Rashes	Anemia	Liver trouble/Hepatitis
Diabetes	Fever Blisters	Profuse bleeding	
Yellow Jaundice	Genital herpes	Excess bruising	

No Yes Have you ever had any surgery(s) or serious injury(s)? [Including cosmetic surgery]

Please list procedure, date and physician: \_\_\_\_\_

No Yes Are you now taking any medications, herbal or weight loss supplements ? Please list them:

\_\_\_\_\_  
\_\_\_\_\_

No Yes Are you allergic to any medication, creams, tape, make-up, etc? Please describe reaction:

\_\_\_\_\_  
\_\_\_\_\_

## Patient Information

No Yes Have you ever taken the drug "Acutane"? When? \_\_\_\_\_

No Yes Do you smoke more than 10 cigarettes a day?

No Yes Do you drink more than 6 cups of coffee a day?

No Yes Do you usually drink two or more alcoholic beverages a day?

When was your last physical examination? \_\_\_\_\_

Who is your primary care physician? \_\_\_\_\_ Phone Number: \_\_\_\_\_

Address \_\_\_\_\_

No Yes May we contact him/her for additional information pertaining to your health?

### Women Only

Date of last menstrual period? \_\_\_\_\_

No Yes N/A Are your periods often irregular?

No Yes Have you had any "female" or GYN problems? Please explain: \_\_\_\_\_

No Yes Do you have any other medical problems that have not yet been covered? Please explain:  
\_\_\_\_\_

## Services

Please indicate which procedure(s) are you interested in:

### **Surgical Services:**

- |   |  |  |   |
|---|--|--|---|
| <input type="checkbox"/> Rhinoplasty (nose)                       | <input type="checkbox"/> Chin Augmentation | <input type="checkbox"/> Facelift                            | <input type="checkbox"/> Cheek or Neck Lift |
| <input type="checkbox"/> Eyelids                                  | <input type="checkbox"/> Chemical Peel     | <input type="checkbox"/> Scar Revision                       | <input type="checkbox"/> Hair Replacement   |
| <input type="checkbox"/> Thermage                                 | <input type="checkbox"/> Protruding Ears   | <input type="checkbox"/> Removal of cysts, warts, moles etc. |   |
| <input type="checkbox"/> Liposuction - Please list area(s): _____ |  |  |   |

### **Skin Clinique' Medi-spa services:**

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Botox Cosmetic      | <input type="checkbox"/> Injectable fillers (Restylane, Radiesse, Collagen, etc.) | <input type="checkbox"/> Photo facials  |
| <input type="checkbox"/> Skin care / Make-up | <input type="checkbox"/> Microdermabrasion  | <input type="checkbox"/> Chemical Peels |
| <input type="checkbox"/> Other _____         |   |   |

Please write, in your own words, what condition(s) you wish to discuss \_\_\_\_\_

No Yes Do you desire improvement in both appearance and function?

No Yes Do you accept the fact that every medical and surgical treatment is associated with risk and other imponderables?

No Yes Have you received and read our information regarding the surgical procedure(s)?

No Yes Do you give consent and authorize the recommended diagnostic, medical, surgical, anesthetic, and other diagnostic services that the Center deems beneficial while you are under their care?

\_\_\_\_\_ (initial) I have received a copy of our Privacy Practice Agreement

*Thank you. The above information you have provided is essential in our comprehensive evaluation in your case. Please read the packet and write down any questions that come to mind so that we may answer them during your consultation. If you don't have the packet, please ask for one; it is an important piece of information for you about your surgery.*

Patient Signature: \_\_\_\_\_

Date: \_\_\_\_\_