



Patient Information

Date _____

Name _____ Social Security # _____
 Address _____ Birth Date _____
 City _____ State _____ Zip _____ Gender Female Male MTF FTM
 Marital Status Single Married Divorced Widowed Other Name of Spouse _____

How did you hear of us? (please be specific) _____
(yellow pages, billboard, newspaper ad, or the name of patient who referred you, etc.)

Contact Information & Privacy Instructions:

OK to phone OK to leave messages

| | | | |
|-------------|---------------|--------------------------|--------------------------|
| Home Phone | (_____) _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| Work Phone | (_____) _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| Cell Phone | (_____) _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| Pager/Other | (_____) _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| E-Mail | _____ | | |

| | | |
|------------------------------|-----------------------------|--|
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Can a message be left with our company name and what the call is in reference to? |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Is there anyone you would like to authorize to schedule, confirm or change appointments? |
| | | Name _____ Relation _____ |

Your Occupation _____ Employer _____
 Address _____ City _____ State _____ Zip _____

Emergency Contact _____ Relation _____ Phone _____

Reason for today's surgical consultation :

- | | | | | | |
|---------------------------------------|--|--|---|---|--|
| <input type="checkbox"/> Arm Lift | <input type="checkbox"/> Breast Augment | <input type="checkbox"/> Breast Lift | <input type="checkbox"/> Breast Reduction | <input type="checkbox"/> Replace Implants | <input type="checkbox"/> Breast, other |
| <input type="checkbox"/> Brow Lift | <input type="checkbox"/> Cheek Implant | <input type="checkbox"/> Chin Implant | <input type="checkbox"/> Eyelid Lift | <input type="checkbox"/> Facelift | <input type="checkbox"/> Fat Injection |
| <input type="checkbox"/> Gluteal Lift | <input type="checkbox"/> Laser Resurfacing | <input type="checkbox"/> Lip Enhancement | <input type="checkbox"/> Neck Lift | <input type="checkbox"/> Otoplasty | <input type="checkbox"/> Rhinoplasty |
| <input type="checkbox"/> Thigh Lift | <input type="checkbox"/> Tummy Tuck | <input type="checkbox"/> Liposuction (specify areas) _____ | | | |

Do you have any skin care concerns?

- | | | | | | |
|---|---------------------------------------|--|---------------------------------------|--|------------------------------------|
| <input type="checkbox"/> Lines/wrinkles | <input type="checkbox"/> Freckles | <input type="checkbox"/> Large pores | <input type="checkbox"/> Dry skin | <input type="checkbox"/> Oily Skin | <input type="checkbox"/> Acne |
| <input type="checkbox"/> Melasma | <input type="checkbox"/> Rosacea | <input type="checkbox"/> Flushing skin | <input type="checkbox"/> Blotchy Skin | <input type="checkbox"/> Sun Spots | <input type="checkbox"/> Red spots |
| <input type="checkbox"/> Blood vessels | <input type="checkbox"/> Facial Veins | <input type="checkbox"/> Facial Scars | <input type="checkbox"/> Cellulite | <input type="checkbox"/> Unwanted hair | |

I, _____, represent to the physician and staff that I am 18 years of age or older. If not, I am accompanied by a legal guardian. I hereby consent to and authorize examination and treatment by my doctor or accredited medical personnel he may assign. **I understand that I am responsible for today's \$50.00 consultation fee, and that checks are not accepted.**

I have been provided a copy of Aesthetic Enhancement's Notice of Privacy Practices. I understand my rights as a patient under the HIPAA Act. I understand my rights to access and control my health information. I understand that I may be contacted by employees of Aesthetic Enhancement to remind me of appointments, healthcare treatment options, or other health service issues. I have selected and give permission for the contact options checked above.

Patient Signature _____ Date _____