Welcome to the Center for Facial Plastic Surgery and
The Center for Facial Aesthetic Skincare

Please Circle the following procedures that you wish to discuss:

Facelift Botox Facial Implants

Eyelid Rejuvenation Fat/Filler Injections Forehead Lift

Rhinoplasty/Septum Laser Resurfacing Revision of Prior Surgery

Please explain specifically what you wish to have corrected and/or your areas of concern?

____

____

____

Please circle any/all of the following that you are interested in learning more about:

Skin Analysis Aging Skin Rejuvenation Broken Capillaries

Chemical Peels Botox Laser Treatments

Dark Circles Wrinkle Reduction Filler Injections

Rosacea Treatment Lip Enhancement Earlobe Repair

Products for: Prevention Correction Acne Eyelash Enhancement

Have you previously had cosmetic procedures performed? **YES** **NO**

If Yes, were you pleased with the results? **YES** **NO** Please explain:_______________

____

____

Do you understand that the object of any cosmetic operation is the improvement of appearance, not perfection? **YES** **NO** And that the result of any operation may not fully meet your expectations? **YES** **NO**

How were you referred to our office? ____

New Patient Registration:

Name: ______________________________Date: _________ Birthdate:__________________________

Address: ____ City: ________________________

Zip Code: ___________________ Home Phone: ____

Cell: ____Marital Status: **S M D SEP W**

Email Address: ____

Occupation: ________________________Referred by: _______________________________________

Emergency Contact Name/Number/Relationship: ______________________________________

____

Responsible Party Information (If Patient is a minor)

Name of Responsible Party: ____

Birthdate: ___________________________Cell Phone: _______________________________________

Address: ____City: ________________________

Zip: _________________________Relationship: ____

Medical Information:

Do you have any allergies? YES NO If YES, please list your reactions

Allergies: Reactions:

____

____

____

____

Please list all current medications & conditions they are treating:
Medications: Conditions:

____

____

____

Please explain any surgical complications or anesthesia reactions:

____

____

Height: _____________ Weight: ___________________ Age: _______________

Recent weight loss/gain: __________Loss: ________Gain: ________

Your Physician: _________________________________Phone# ________________________

Please Circle any/all of the following that apply to you:

Anemeia Anxiety Arthritis Thyroid Disease
Asthma Cancer Chest Pains

Depression Diabetes Glaucoma

Headaches Heart Attack Heart Murmer

Hepatitis/Jaundice High Blood Pressure Liver Disorder

Malignant Hyperthermia Neurologic Disorder Neuromuscular Disorder

Seizures Skin Problems Sleep Apnea

Please list any medical conditions that have not been covered above: _______________

____

Do you have any heart conditions? **Yes** **No** Please explain:

____

Please list *any* Previous Surgeries:

Procedure: Year: Local or General Anesthesia:

____

____

____

____

The information that you have provided us is essential in our comprehensive evaluation of your case. Please feel free to write down any questions that you may have so that we may discuss them in detail during your consultation.
Thank you for choosing The Center for Facial Plastic Surgery!

Signature: ____Date: ____________________

Doctor's Initials: ___________