

***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?

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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: \_\_\_\_\_

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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:**

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Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Age: \_\_\_\_\_

Recent weight loss/gain: \_\_\_\_\_ Loss: \_\_\_\_\_ Gain: \_\_\_\_\_

Your Physician: \_\_\_\_\_ Phone# \_\_\_\_\_

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

Anemia	Anxiety	Arthritis	Thyroid Disease
Asthma	Cancer	Chest Pains	
Depression	Diabetes	Glaucoma	
Headaches	Heart Attack	Heart Murmur	
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: \_\_\_\_\_

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

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**Please list any Cosmetic and/or Non Cosmetic Surgery:**

Procedure:                      Year:                      Local or General Anesthesia:

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*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:** \_\_\_\_\_