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PATIENT INTAKE FORM FOR MEDICAL COSMETIC TREATMENT

Name _____ Birth Date ____/_____/_____Age _____

Address _____

City _____ State _____ Zip _____

Home Tel. _____ Work Tel. _____ Cell _____

Email Address _____

May we send promotional materials to you via email? _____ Yes _____ No

Emergency Contact _____ Tel. _____

May we contact you at home? _____ By email? _____ By cell phone? _____

How were you referred to our Practice? _____

Have you ever had any Medical Cosmetic Treatments? _____

Please check off the procedures which are of interest to you.

Botox _____ Photorejuvenation _____ Vein Treatment _____

Cosmetic Filers _____ Mesotherapy _____ Liposuction _____

Others (please specify) _____

Medical History:

What is your usual height and weight? _____

List any medical problems that you have _____

List any medications that you are taking _____

List any allergies that you have _____

List any previous surgeries you have had _____

Patient Signature _____ Date _____