Aesthetic Enhancement
COSMETIC SURGERY & LASER CENTER

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	(_____)_____	☐	☐
Work Phone	(_____)_____	☐	☐
Cell Phone	(_____)_____	☐	☐
Pager/Other	(_____)_____	☐	☐
E-Mail	_____		

☐ Yes ☐ No Can a message be left with our company name and what the call is in reference to?
☐ Yes ☐ 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 :

☐ Arm Lift	☐ Breast Augment	☐ Breast Lift	☐ Breast Reduction	☐ Replace Implants	☐ Breast, other
☐ Brow Lift	☐ Cheek Implant	☐ Chin Implant	☐ Eyelid Lift	☐ Facelift	☐ Fat Injection
☐ Gluteal Lift	☐ Laser Resurfacing	☐ Lip Enhancement	☐ Neck Lift	☐ Otoplasty	☐ Rhinoplasty
☐ Thigh Lift	☐ Tummy Tuck	☐ Liposuction *(specify areas)* _____			

Do you have any skin care concerns?

☐ Lines/wrinkles	☐ Freckles	☐ Large pores	☐ Dry skin	☐ Oily Skin	☐ Acne
☐ Melasma	☐ Rosacea	☐ Flushing skin	☐ Blotchy Skin	☐ Sun Spots	☐ Red spots
☐ Blood vessels	☐ Facial Veins	☐ Facial Scars	☐ Cellulite	☐ 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 _____