DrYoungForever
Plastic Surgery Center
& MedSpa

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)* _____
(doctor's website, 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	(_____)_____	☐	☐
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 _____

Pharmacy _____ Location _____ 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)* _____			

Other: _____

I, _____, represent that I am 18 years of age or older or are accompanied by a legal guardian. I hereby consent to and authorize examination and treatment by my doctor or the medical personnel he may assign to assist in my care. **I understand that personal checks are not accepted and payments may be made by cash, bank check, credit or debit cards, money order, PayPal, CareCredit. Finance may be available upon credit approval with independent finance companies.**

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

Patient Signature _____ Date _____