



6425 POST ROAD, SUITE 102  
 DUBLIN, OH 43016  
 P: 614.336.9000  
 F: 614.336.9001  
 WWW.CCCSURGERY.COM

## New Patient Information

Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_  
First
Middle
Last

**What brings you to the office today (Be as specific as possible)?**

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**What are your areas of concern? (Please check all that apply)**

Breasts	Facial aging or shape	Body contouring
<input type="checkbox"/> Smaller than desired breasts <input type="checkbox"/> Sagging breasts <input type="checkbox"/> Large breasts <input type="checkbox"/> Large areolas or nipples <input type="checkbox"/> Inverted nipples <input type="checkbox"/> Breast shape <input type="checkbox"/> Different sized breasts <input type="checkbox"/> Breast reconstruction <input type="checkbox"/> Male breast development	<input type="checkbox"/> General facial aging <input type="checkbox"/> Deep nasolabial folds <input type="checkbox"/> Jowling <input type="checkbox"/> Weak cheekbones <input type="checkbox"/> Weak chin <input type="checkbox"/> Sagging neck skin <input type="checkbox"/> Excess chin fat <input type="checkbox"/> Brow frown lines <input type="checkbox"/> Fine lines and wrinkles <input type="checkbox"/> Lines around nose and mouth <input type="checkbox"/> Rough skin texture <input type="checkbox"/> Sagging skin	<input type="checkbox"/> Body contour irregularities or excess fat <input type="checkbox"/> Bulging belly <input type="checkbox"/> Loose belly skin <input type="checkbox"/> Loose arm skin <input type="checkbox"/> Loose thigh skin <input type="checkbox"/> Drooping buttock <input type="checkbox"/> Poorly shaped buttock <input type="checkbox"/> History of massive weightloss <input type="checkbox"/> Unwanted hair <input type="checkbox"/> Aged appearing hands

**Are you interested in learning more about the following treatments? (Please check all that apply)**

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> BOTOX Cosmetic <sup>®</sup><br><input type="checkbox"/> Injectable fillers (Restylane, Juvederm, Prevelle, etc.)<br><input type="checkbox"/> Hair removal<br><input type="checkbox"/> Chemical Peels<br><input type="checkbox"/> Skin rejuvenation<br><input type="checkbox"/> Retin-A<br><input type="checkbox"/> Microdermabrasion | <input type="checkbox"/> Acne treatments<br><input type="checkbox"/> Acne scar reduction<br><input type="checkbox"/> Chemical peels<br><input type="checkbox"/> Laser treatments<br><input type="checkbox"/> Skin analysis<br><input type="checkbox"/> Skin care products<br><input type="checkbox"/> Birthmarks<br><input type="checkbox"/> Liver/age spots | <input type="checkbox"/> Sun protection<br><input type="checkbox"/> Facial vein removal<br><input type="checkbox"/> Leg vein removal<br><input type="checkbox"/> Ultrasound treatments<br><input type="checkbox"/> Aquadetox |
|---|--|--|

Other:

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### Demographics

Name: \_\_\_\_\_  
SSN: \_\_\_\_\_ Birthdate: \_\_\_\_\_  
Home Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

[Only fill out the numbers where you wish to be contacted.]  
Home Phone: ( ) \_\_\_\_\_ Work Phone: ( ) \_\_\_\_\_  
Cell Phone: ( ) \_\_\_\_\_ E-mail: \_\_\_\_\_

Occupation: \_\_\_\_\_  
Employer: \_\_\_\_\_ Years There: \_\_\_\_\_  
Employer's Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Name of Spouse: \_\_\_\_\_  
Occupation: \_\_\_\_\_  
Employer: \_\_\_\_\_ Years There: \_\_\_\_\_  
Employer's Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Employer's Telephone: ( ) \_\_\_\_\_

In case of emergency, contact: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Home Phone: ( ) \_\_\_\_\_ Work Phone: ( ) \_\_\_\_\_  
Cell Phone: ( ) \_\_\_\_\_ E-mail: \_\_\_\_\_

How did you learn about Capital City Cosmetic Surgery?

- Doctor referral: (Name & Address) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
- Patient: \_\_\_\_\_
- Yellow pages
- Direct mailing
- Internet search
  - Lookingyourbest.com
  - Love your look.com
  - Search site: \_\_\_\_\_
- Published ad: \_\_\_\_\_
- Radio ad: \_\_\_\_\_

