New Patient Information

Name: Today's Date:

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

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

❑ BOTOX Cosmetic©
❑ Injectable fillers (Restylane, Juvederm, Prevelle, etc.)
❑ Hair removal
❑ Chemical Peels
❑ Skin rejuvenation
❑ Retin-A
❑ Microdermabrasion

❑ Acne treatments
❑ Acne scar reduction
❑ Ultherapy
❑ Laser treatments
❑ Skin analysis
❑ Skin care products
❑ Birthmarks
❑ Liver/age spots

❑ Sun protection
❑ Facial vein removal
❑ Leg vein removal
❑ Ultrasound treatments
❑ Aquadetox

Other:

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New Patient Information Continued

Name: Today's Date:

Demographics

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:_________________________________
If you'd like to receive text notifications, please list your cell carrier: _____________________

Occupation: ____
Employer: ____

- ❑ Heavy lifting/activity required

Name of Pharmacy:____
Street:____ City:____________________
Phone:_________________

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
  - ❑ MyPlasticSurgeon.com
  - ❑ EBreastAug.com
  - ❑ Implants411.com
  - ❑ Search site: ___________________
- ❑ Published ad: ______________________
- ❑ Radio ad (specify station):___________________________
- ❑ Television Commercial (specify channel):____________________________
- ❑ Television News Segment (specify channel):_________________________