DeFatta
FACIAL PLASTICS

*Thank you for choosing our office! In order to serve you properly, we need the following information.*

Patient's Legal Name: ____________________________ Maiden Name: ___________________

Address: _________________________________City:_______________State:_______Zip:________

Birthdate: __________________________ ☐ Male ☐ Female

Home Phone#:________________________________ Cell Phone#:___________________________

Email Address: ________________________________________

Preferred Method of Contact: ☐ Cell ☐ Home ☐ Text ☐ Email

Please Check One: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Race: ☐ White ☐ Asian ☐ African American ☐ American Indian ☐ Hispanic ☐ other:

Emergency Contact Name: ___________________________________________

Phone Number: ________________________ Relationship to patient______________

Primary Care Physician: _______________________

How were you referred to us: ☐ Our website ☐ Internet search ☐ Advertisement ☐ Facebook
☐ Friend (name) ___________________________ ☐ Physician (name) _______________________

**WHAT BOTHERS YOU?** (Check all that apply)

EYES:
☐ droopy lids ☐ puffy lower lids ☐ sagging lower lids ☐ dark circles/under eye hollows
☐ brow sagging ☐ inadequate lashes

FACIAL FULLNESS:
☐ losing volume/fullness ☐ face appears "tired" or "less fresh"

LOWER FACE:
☐ sagging jaw line ☐ sagging neck ☐ facial folds ☐ thin lips

NOSE:
☐ dissatisfied with shape ☐ difficulty breathing ☐ unhappy with previous surgery

SKIN:
☐ fine lines and wrinkles ☐ blotchy appearance/sun spots

OTHER:

DO YOU HAVE ANY OF THE FOLLOWING CONDITIONS? (Please check all that apply)
☐ anemia ☐ bleeding problems ☐ blood clots ☐ diabetes ☐ difficulty breathing through nose
☐ earaches ☐ heart disease ☐ high blood pressure ☐ scarring/keloids ☐ shortness of breath
☐ sinus infections ☐ snoring

PLEASE LIST ANY SURGERIES OR OTHER MAJOR ILLNESSES:

DO YOU HAVE ANY ALLERGIES TO MEDICATIONS?

Name Reaction

______________________________________________________________________
______________________________________________________________________
______________________________________________________________________
______________________________________________________________________

LIST OF MEDICATIONS:
______________________________________________________________________
______________________________________________________________________
______________________________________________________________________

**PAYMENT POLICY**
CONSULTATIONS: There is a $50 service charge for all cosmetic consultations. This amount will be deducted from the cost of your cosmetic procedure.

IN-OFFICE PROCEDURES: Payment for all in-office procedures are due on the day of service.

OPERATING ROOM PROCEDURES: Half of the total cost of the procedure is due upon scheduling your surgery date. Full payment is required no later than 1 week before surgery.

**PAYMENT METHODS**
For your convenience, we accept cash, checks, credit cards, and debit cards.

**RETURNED CHECKS**
There is a fee of $25.00 for checks returned by the bank for non-sufficient funds.

*Please sign*
Accepted and agreed: ________________________________ ________________
Patient or Legal Guardian Signature Date

Witnessed: ________________________________ ________________
Employee Signature Date