Lone Tree Facial Plastic & Cosmetic Surgery Center

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Patient Information

Name: _____
Address: _____
City: _____ State: ____ Zip: _____
DOB: _____ Sex: F ☐ M ☐
SSN: _____
Marital Status: _____
Home Phone: (_____) _____-_____
Cell Phone: (_____) _____-_____
E-Mail Address: _____

Occupation: _____
Employer: _____
Work Phone: (_____) _____-_____
Address: _____
City: _____ State: _____ Zip: _____

Family Doctor Name: _____
Office Phone: (_____) _____-_____
Address: _____
City: _____ State: _____ Zip: _____
Pharmacy Name: _____
Pharmacy Phone: _____
Address: _____
City: _____ State: _____ Zip: _____

How were you referred to our office?

☐ Doctor: _____
Phone: (_____) _____-_____

☐ Family: _____
☐ Friend: _____
☐ Internet ☐ Insurance Book ☐ Radio
☐ Magazine ☐ Newspaper ☐ Yellow Pages

Spouse or Parent Information

Name: _____
Address: _____
City: _____ State: _____ Zip: _____
DOB: _____ SSN: _____
Home Phone: (_____) _____-_____
Cell Phone: (_____) _____-_____

Notes and Comments

_____
_____
_____
_____
_____

Contact In Case Of Emergency

Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Relationship: _____
Home Phone: (_____) _____-_____
Cell Phone: (_____) _____-_____

Personal Medical History

Age: _____ Height: _____ Weight: _____
Drug Allergies? ☐ No ☐ Yes Reactions
1) _____ _____
2) _____ _____
3) _____ _____

Current Medications Dosages
1) _____ _____
2) _____ _____
3) _____ _____

Are you on any medications containing ASPIRIN?
☐ No ☐ Yes Dosage: _____
Previous Surgical Procedures Dates
1) _____ _____
2) _____ _____
3) _____ _____

Major Illnesses- (CIRCLE)

N/A High Blood Pressure Diabetes Cancer Lung Disease
Heart Disease Kidney/Liver Problems
Others: _____

Do you or any family members have a history of easy bruising or excessive bleeding?
☐ No ☐ Yes
Do you or any family members have a history of anesthesia issues (high fever, slow to emerge)?
☐ No ☐ Yes
Are you pregnant? ☐ No ☐ Yes
Smoker? ☐ No ☐ Yes
How many packs per day? ___
For how long? ___Years ___Months
If you have quit, for how long? ___Years ___Months
Alcohol? ☐ No ☐ Yes
If Yes, how many servings per day? _____
For how long? __Years ___Months

I certify that the above information is accurate.
X_____ Date: _____

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