AESTHETIC CENTER OF PLASTIC SURGERY

888-747-0177

(Please Print Legibly & Fill In or Correct All Fields)

Patient's Name _____
First Middle Last

Address _____
Street & Apt # City State Zip

Home Phone _____ Cell Phone _____ Other Phone _____

Any restrictions for contacting you? ❒ No ❒ Yes E-mail _____

Contact Restrictions: _____

Age _____ Birthdate _____ SS# _____ Gender ❒ Female ❒ Male

Marital Status ❒ Single ❒ Married to: _____ _____

Patient's Employer _____ Occupation _____

Work Phone _____ Ext: _____ Is it okay to call you at work? ❒ Yes ❒ No

Address _____
Street & Suite # City State Zip

How did you hear about ? (Mark all that apply)

❒ Phone Book: ❒SRT ❒Yellowbook ❒Dex ❒ Web:_____ ❒ Doctor:_____ ❒ Friend/Relative:_____

❒Off The Wall Advertising ❒ Other:_____

Emergency Contact
(or Responsible Party) _____ Relationship to Patient _____

Home Phone _____ Work Phone _____ Other Phone _____

Areas of Interest: (mark all that apply)

Facial Procedures

❒ Blepharoplasty (Eyelid Lift)
❒ Botox
❒ Brow or Forehead Lift
❒ Face or Neck Lift
❒ Lip Enhancement
❒ Otoplasty (Ear Pinning)
❒ Rhinoplasty (Nose Reshaping)
❒ Skin Resurfacing (Laser, Peel, Etc.)
❒ Wrinkle Fillers (Injections)

Breast Procedures

❒ Breast Augmentation
❒ Breast Reconstruction
❒ Breast Reduction
❒ Mastopexy (Breast Lift)
❒ Nipple Reduction or Inversion

Body Procedures

❒ Abdominoplasty (Tummy Tuck)
❒ Brachioplasty (Arm Lift)
❒ Full Body Lift
❒ Liposelection (Thighs, Abdomen)

Other Procedures

❒ Skin Care
❒ Telangectasia (spider veins)
❒ Laser Hair Removal
❒ Laser Tattoo Removal

I understand that office visit charges are payable on the day service is rendered. I authorize Dr. Paulson to bill my insurance company. Regardless of insurance coverage, I am responsible for all bills being paid in a timely manner. I understand that my contract is between Dr. Paulson and myself. ❒

Signature _____ **Date** _____

Would you like a complimentary skin evaluation while you are here today? ❒ Yes ❒ No