

Patient Information as of _____ (enter today's date)
(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 _____

E-mail _____

Age _____ Birthdate ____ / ____ / ____ SS# ____ - ____ - ____ Gender Female Male

Marital Status Single Married to: _____ Other: _____

Occupation _____ Work Phone _____

Is it okay to call you at work? Yes No

How did you hear about Dr. Gross? _____

If you were referred by a specific person, may we thank them? Yes No

Emergency Contact
(Not in your household) _____ Relationship to Patient _____

Home Phone _____ Work Phone _____ Other Phone _____

Areas of Interest: (mark all that apply)

Injections

- Botox
- Juvederm/Restylane
- Fat injection
- Evolence

Laser Procedures

- Laser Hair Removal
- Skin Resurfacing (Laser, Peel, Etc.)

Surgical Procedures

- Face/Neck or Brow Lift
- Tummy Tuck
- Breast Augmentation or Lift
- Breast Reduction
- Eyelid, Chin or Cheek improvement
- Liposuction
- Rhinoplasty/Nose Improvement
- Otoplasty (Ear)

Other

- Acne
- Skin Care
- Skin Aging/Rejuvenation
- Telangectasia (spider veins face)
- Latisse
- Photofacials (trmt brown/red color)
- Microdermabrasion
- Varicose Veins

Are you interested in meeting with one of our professional cosmetic consultants in order to create a Personal Treatment Plan designed to meet your cosmetic needs? YES No thanks

Please answer the following questions on a scale of 1 to 5 by circling the appropriate number.

When looking at my face in the mirror, I believe I look younger, the same as, or older than my true age.

Younger Than		True Age		Older Than
1	2	3	4	5

When looking in the mirror, I am not concerned, somewhat concerned, or very concerned about the appearance of my wrinkles.

Not Concerned		Somewhat Concerned		Very Concerned
1	2	3	4	5

I understand that office visit charges are payable on the day service is rendered.

Signature _____ **Date** _____