



Patient Information Form

**Information must be completed prior to consultation.
Please fill out and bring it with you on that appointment.**

Cosmetic Surgery Center, Inc. • 9617 S. Pennsylvania • Oklahoma City, OK 73159 * Phone: 405-691-3111
Fax: 405-692-2064 email: cosmeticsurgerycenter@coxinet.net

Date: _____

Patient Name: _____ Birth Date _____ Age _____

Address: _____

City _____ State _____ Zip _____ SS# _____ / _____ / _____

Phone: Home () _____ Cell: () _____ email: _____

If patient is a minor / Responsible Parent's name: _____

Patient's Employer Information (Please use Responsible Parent's information if Patient is a Minor):

Employer _____ Work Phone () _____ How Long _____

City, State _____ Position _____

Nearest relative not living with you to notify in case of emergency:

Name _____ Relationship _____

City, State _____ Home Phone _____ Cell _____ Work Phone _____

Would you like to receive periodic information from us by email? Yes No Email _____
such as Newsletters and Special Discounts

MEDICAL HISTORY

Check any of the following you have experienced:

- | | | | | |
|--|---|--|---|--|
| <input type="checkbox"/> Thyroid Therapy | <input type="checkbox"/> Steroid therapy | <input type="checkbox"/> Venereal disease | <input type="checkbox"/> Profuse bleeding | <input type="checkbox"/> Other stomach trouble |
| <input type="checkbox"/> Lung trouble | <input type="checkbox"/> Kidney trouble | <input type="checkbox"/> Frequent headache | <input type="checkbox"/> Heart trouble | <input type="checkbox"/> Other Blood problems |
| <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Psoriasis | <input type="checkbox"/> Keloid scars | <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> High blood pressure |
| <input type="checkbox"/> Hay fever | <input type="checkbox"/> Yellow Jaundice | <input type="checkbox"/> Rashes | <input type="checkbox"/> Paralysis | <input type="checkbox"/> Nervous Breakdown |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Shingles | <input type="checkbox"/> Blood Disorders | <input type="checkbox"/> Cancer or Radiation | <input type="checkbox"/> Drug Abuse therapy |
| <input type="checkbox"/> Bladder Trouble | <input type="checkbox"/> Excessive Scarring | <input type="checkbox"/> Skin Infection | <input type="checkbox"/> Skin Pigmentation | <input type="checkbox"/> Gall bladder trouble |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Skin Irritation | <input type="checkbox"/> Convulsions | <input type="checkbox"/> Bouts of unhappiness |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Stomach ulcers | <input type="checkbox"/> Fever blisters | <input type="checkbox"/> Hormone therapy | <input type="checkbox"/> Psychiatric therapy |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Visual problems | <input type="checkbox"/> Genital Herpes | <input type="checkbox"/> Burns / Grafted Skin | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> AIDS | <input type="checkbox"/> Excessive bruising | <input type="checkbox"/> Liver trouble | <input type="checkbox"/> Poor Circulation | <input type="checkbox"/> Frequent Chest pain |
| <input type="checkbox"/> Acne | <input type="checkbox"/> Herpes (or cold sores) | <input type="checkbox"/> Melanoma | <input type="checkbox"/> Bouts of Depression | <input type="checkbox"/> Alcohol abuse therapy |

Do you have any other medical problems that have not been covered?

Patient' Race: Caucasian African American Hispanic Asian Other _____

Do you smoke 10 + cigarettes a day? Yes No Do you drink more than 6 cups of coffee a day Yes No

Do you take two or more alcoholic drinks a day? Yes No

Have you had any previous surgery? Yes No Please list them: _____

Are you now taking any drugs or medications? Yes No Please list them: _____

Are you allergic to any medications, creams, tapes, etc? Yes No List: _____

Women only / Date of last menstrual period? _____ Are your periods often irregular Yes No

Name of family doctor? _____ phone: _____

Address: _____

May we contact your doctor for additional information pertaining to your health? Yes No

How did you hear about us? _____

My friend told me about your services (If you would like us to email your friend a \$50 gift certificate of thanks, please list....)

Friend's name: _____ email or phone # _____

My doctor: _____

Ad on television / radio I wanted to see a Board Certified Physician

I found you in the Yellow Pages Driving by I saw your building

I visited your website I found you on Google Yahoo

Other _____

Other procedures of interest to you (Check all that apply)

Liposculpting Chemical resurfacing Fat transfer Permanent makeup

Chin implant Laser resurfacing Tummy Tuck Eyelid lifting

Cheek implant Face lift Breast enlargement Longer, thicker eyelashes - *Latisse™*

Lip enhancement Brow lift Breast reduction Spider vein reduction

Thigh lift Ear Pinning Breast lift Facial Fillers - *Radiesse - Juvederm - Sculptra - Artefill*

Arm lift Fix earring tears Male breast reduction

Botox Other: _____

Do you accept the fact that every medical and surgical treatment is associated with risk and other imponderables? Yes No

Do you give consent and authorize the recommended diagnostic, medical, surgical, anesthetic and other diagnostic services that the Cosmetic Surgery center deems beneficial while you are under our care? Yes No

I agree that all the information contained on this form is true and correct to the best of my knowledge.

Patient's Signature: _____

Signature of Parent or Guardian if patient is a minor.

Date: _____

Please be advised that we are not a member of any PPO or HMO, and payment is due at the time service is rendered. We will provide you (upon request) information to file for reimbursement by your insurance company.
Please visit our website for financing options.