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Neigel
Center
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101 Old Short Hills Road ◆ Suite 204 ◆ West Orange, NJ 07052 ◆ Tel 973-325-7779 ◆ Fax: 973-325-7914

Cosmetic Patient Interest & Authorization

Patient Name: _____ **Birth Date:** ____/____/____ **Age:** _____

Street Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Email Address: _____@_____._____ **Cell Phone:** (____)____-_____

Home Phone: (____)____-_____ Male Female **SSN:** ____-____-_____ **Occupation:** _____

Marital Status: S M D/S W **Pharmacy:** _____ **Phone:** (____)____-_____

Medical Doctor: _____ **Address:** _____ **Phone:** (____)____-_____

Advance Directive: Yes No **Emergency Contact:** _____ **Phone:** (____)____-_____

Circle the cosmetic procedures you are interested in:

Blotchy Skin Body Contouring BOTOX or Dysport Breast Size Broken Capillaries Brown Spots/Age Spots/Freckles Brow Lift Breast Augmentation Breast Reduction Chemical Peels Drooping Brow/Eyelids Facials Facial Contouring	Facial Fine lines/wrinkles Facial Fullness/Drooping Fat Injections Full Face Lift Hair Removal Injectable Treatments Juvederm (or other filler) Laser Skin Resurfacing Laser Treatments Length/Fullness of Eyelashes Liposuction Make – Up Microdermabrasion Mole Removal	Neck Lift /Wrinkles Nose Size or Shape Restylane (or other filler) Scar Removal /Revision S – Lift (Mini Face Lift) Sculptra Skin Care Advice/Products Tattoo Removal Thin lips Tummy Tuck Veins Face or Legs Wrinkle Erasing/Cool Touch Other: _____
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1. Do you take aspirin, Motrin or NSAID's? _____ If yes, have you taken it in the last week? _____ Dose/Frequency _____

2. Do you have bleeding tendencies?

3. Have you taken any cortisone or steroids in the past 6 months?

4. Do you have a cold or cough?

5. Have you ever had a problem with anesthesia?

6. Has anyone related to you ever had problem with anesthesia?

7. Do you have asthma or difficulty breathing?

8. Do you smoke?

9. Do you have a heart murmur?

10. Have you ever had a heart attack?

11. Have you ever had angina or pain in your chest?

12. Could you be pregnant?

13. Have you ever had thyroid problems?

15. Have you ever been jaundiced or had hepatitis?

16. Do you have heartburn, hiatal hernia or ulcers?

17. Do you have diabetes?

18. Do you have kidney disease?

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.

<i>Younger Than</i>		<i>True Age</i>		<i>Older Than</i>
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.

<i>Not Concerned</i>		<i>Somewhat Concerned</i>		<i>Very Concerned</i>
1	2	3	4	5

How did you hear about us?

<input type="checkbox"/> My physician	<i>Full name:</i>
<input type="checkbox"/> My insurance company provider	<i>Name:</i>
<input type="checkbox"/> The yellow pages	<i>Specify Ad:</i>
<input type="checkbox"/> A friend or family member	<i>Name:</i>
<input type="checkbox"/> Internet	
<input type="checkbox"/> The Physician/Practice website	
<input type="checkbox"/> Seminar	<i>Date/location:</i>
<input type="checkbox"/> Other	

<input type="checkbox"/> Approval to contact you.	<i>Best phone number to reach you:</i>
<input type="checkbox"/> Approval to send you information on products and services (including special offers)	<i>Email address:</i>

I'm not interested in any additional services provided at this time

↓ For Staff Use Only ↓

Physician / provider :	<i>Date</i>	<i>Completed by (name)</i>
<input type="checkbox"/> <i>Follow-up</i>		
<input type="checkbox"/> Initial Inquiry/Information Given		
<input type="checkbox"/> Contact in future – give date		
<input type="checkbox"/> Products		
<input type="checkbox"/> Free consultation		
<input type="checkbox"/> Procedure scheduled		
<input type="checkbox"/> Procedure completed		

Comments:

I understand that aesthetic (cosmetic) surgery is not a covered benefit of Medicare and other insurance carriers. Therefore any aesthetic procedure will be my financial responsibility and payment in full will be expected prior to the procedure. I consent to photographing of my face and appropriated portions of my body and to the modification, display, and publication of such photographs for medical, scientific, or educational purposes provided that I am not identified by name.

Patient Signature: _____ **Date:** _____