

Cincinnati Facial Plastic Surgery
Alexander S. Donath, MD
Registration Form

Date _____

Name _____
First Middle Last

Address _____
Number Street City State Zip Code

May we mail to the above address? (y/n) _____ (if no, please indicate location to mail to below)

Number Street City State Zip Code

Birthdate _____ Age _____ E Mail Address _____ May we email you (y/n) _____

Phone Number _____ *please put a star next to preferred number
(Home) (Cell) for us to call you.

Employer _____ Position _____ Phone Number _____

May we call you at this number? (y/n) _____

Emergency Contact Person _____ Relationship _____ Phone Number _____

How did you hear about our office?

Friend _____ (Name) _____ Relative _____

Co-Worker _____ Urban Active(Gold's Gym) _____ Web Site (name) or search _____

Dr./Patient Referral _____ (Name) _____ Elegant Permanent Cosmetics _____ Salon _____

P&G credit union _____ Newspaper _____ (Which one) _____

Radio _____ TV _____ Other _____

Reason for today's visit:

Procedures I would like to discuss with the doctor:

Facial Rejuvenation: Necklift ___ Facelift ___ Eyelid Correction ___ Forehead/Brow Lift ___ Fat Transfer _____

Nasal Surgery: ___ Cosmetic ___ Corrective ___ Sinus/Septum Problems _____

Profile Surgery: Chin Implant ___ Cheek Implant ___ Facial/Neck Liposuction _____

Ear Surgery: Reduce Prominence ___ Reduce Earlobe Size ___ Repair Torn Earlobe _____

Skin Rejuvenation: Skin growths/moles ___ Wrinkles ___ Pigmentation/Age Spots ___ Redness/Rosacea ___

Broken Blood Vessels ___ Roughness ___ Scars ___ Large pores ___ Acne ___ Acne Scarring ___ Other _____

Injectables: Botox ___ Restylane ___ Radiesse ___ Sculptra ___ Lip Augmentation ___ Juvederm ___ Other _____

Other Procedures: Hair removal ___ Hair Transplant ___ Microdermabrasion Peel ___ Chemical peel ___

Spider Veins: ___ Face ___ Legs

Facial Soft Tissue Augmentation _____ **Areas** _____

ALLERGIES _____

Medications (please list all)

Do you take any of the following (circle): Aspirin, Advil motrin ibuprofen Coumadin Birth control pills Vit E Ginkgo
St.John's Wort Ginseng Blood pressure meds (please list) _____

Medical History (check all that applies)

Date of last physical _____

Heart Disease ___ Smoking (y/n) ___ #packs ___ per _____

High Blood Pressure ___ Alcohol (y/n) ___ (frequency) ___ per _____

Heart Attack ___ (drink socially only) _____

Respiratory Condition ___ Eye problems ___ Emphysema ___ Urinary ___ Neurological Disease _____

Diabetes ___ Nose problems ___ Asthma ___ Thyroid Disease ___ Facial Trauma _____

Cancer ___ Ear Problems ___ Blood Disease ___ Anemia ___ Emotional problems _____

Gastro-Intestinal Condition ___ Bleeding Problems ___ Jaundice/Hepatitis ___ HIV _____

Past Surgeries (please list all, including cosmetic): _____

All professional services are charged to the patient. The patient is responsible for all the fees regardless of the insurance coverage. I understand that I am responsible for my bill.

If you are eligible for any insurance benefits, please have a copy made of your card with our receptionist.

DISCLOSURE: I understand that Dr. Alexander S. Donath has a financial interest in the Surgical Center of Evendale.

I have read and understand the above. All of the information above is correct and I acknowledge this with my signature below.

Signature _____ Date _____