Updated 1/7/2015

Cincinnati Facial Plastic Surgery
ALEXANDER S. DONATH, M.D., F.A.C.S.

Registration Form

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** _____

Primary Care Physician _____

How did you hear about our office? (Please circle any/ all that apply)
Friend (Name) _____ Relative_____Co-Worker_____
Web Site (name) or search _____ Dr. /Patient Referral (Name) _____
Elegant Permanent Cosmetics Salon (Name) _____ Magazine (Which one)_____
Radio TV Other_____

Reason for today's visit? (Please circle any/all that apply)

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

Injectables: Botox Filler

Hair Transplant

ALLERGIES: _____
Medications (please list all) _____
Current Vitamins, Holistic Medications _____

Do you take any of the following (circle): Aspirin Advil Motrin ibuprofen Coumadin Birth Control Pills Vit E Gingko
St. John's Wort Ginseng Hormone Replacement 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	___	**Caffeine (y/n)**	____ **(cups)** _____**per**_____								
Respiratory Condition	___	Eye problems	____	Emphysema	___	Urinary	___	Neurological Disease	___		
Diabetes	___	Nose problems	____	Asthma	___	HIV	___	Mitral Valve Prolapse	___		
Thyroid Disease	___	Ear Problems	____	Blood Disease	___	Anemia	___	Emotional problems	___		
Multiple Miscarriages	___	Stomach Ulcers	____	Facial Trauma	___	Cancer	___	Poor Healing/Scarring	___		
Gastro-Intestinal Condition	___	Bleeding Problems	____	Jaundice/Hepatitis	___			DVT/PE/Blood Clots	____		

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 of your insurance card and give to our receptionist.

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

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

Signature _____ Date _____ Time _____

Witness _____ Date _____ Time _____