



**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 for us to call you.  
 (Home) (Cell)

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)**

<b>Facial Rejuvenation:</b> Necklift	Facelift	Eyelid Correction	Forehead/Brow Lift	Fat Transfer
<b>Nasal Surgery:</b> Cosmetic	Corrective	Sinus/Septum Problems		
<b>Profile Surgery:</b> Chin Implant	Cheek Implant	Facial/Neck Liposuction		
<b>Ear Surgery:</b> Reduce Prominence	Reduce Earlobe Size	Repair Torn Earlobe		
<b>Injectables:</b> Botox	Filler			
<b>Hair Transplant</b>				

**ALLERGIES/ REACTIONS:** \_\_\_\_\_

**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 Ginkgo 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 \_\_\_\_\_