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**_____

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
Injectables: Botox Filler **Hair Transplant** **Liposonix** **Clear and Brilliant** **Hand Rejevenation**
Would you like someone to teach you how to take the best care of your skin? _____

Medical History (check all that applies)

Date of last physical_____
Smoking (y/n) ____ **# packs** _____ **per** _____
Alcohol (y/n) ____ **(frequency)** ___ **per**_____
Caffeine (y/n) ____ **(cups)** _____**per**_____

Heart Disease	___										
High Blood Pressure	___										
Heart Attack	___										
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	____		

Drug or Alcohol Dependency/Addiction ___

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

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) _____

ALLERGIES/REACTIONS:_____

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.***

In case a photo needs to be sent or received via text/email/sms per the doctor's request we ask that you sign this form. I wish to send/receive communication via text/email/sms of myself in order to communicate quickly and efficiently with the doctor and staff. This is not a secure mode of communication and possibly could be intercepted by 3rd parties. By my signature below I express my understanding of this.

No photography or videography of any kind is permitted anywhere in the office except by staff. Any such photography/videography shall be the copyright of Cincinnati Facial Plastic Surgery, LLC.

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 _____ Time _____

Witness _____ Date _____ Time _____