HIGHLY ARTISTIC SURGERY

REQUEST FOR PATIENT'S INFORMATION

PERSONAL INFORMATION

Name _____
First M. Last

Address_____

Social Security _____ Date of Birth _____

Home Phone # _____ Work Phone # _____ Cell Phone # _____

Email _____

What is the best phone number to reach you? ☐ Home ☐ Work ☐ Cell

May we leave a voice message on your Home/Work/Cell phone number? ☐ Yes ☐ No

May we email you regarding marketing information and special events/promotions? ☐ Yes ☐ No

Who, if anyone, may we have your authorization to release your medical information if they should contact us?
Name _____ Relationship _____
Name _____ Relationship _____
Name _____ Relationship _____

Who may we contact in an Emergency _____
Relationship _____ Phone Number _____

Your Primary Doctor's Name _____
Address _____
Phone Number _____

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TREATMENT INFORMATION

How did you hear about Highly Artistic Surgery?

☐ Newspaper ☐ Internet ☐ Referred By: _____ ☐ Other: _____

What do you hope to accomplish at Highly Artistic Surgery?

_____
_____
_____

What factors prompted you to contact Highly Artistic Surgery?

_____
_____

Please share any medical and/or emotional concerns that you are currently experiencing or have experienced in the past.

_____
_____
_____
_____

If you have received help for any of these concerns, please provide the doctor's name.

_____

Are you interested in learning about other services offered by Highly Artistic Surgery?

If, yes please check all services you are interested in learning about.

- ☐ Plastic Surgery
- ☐ Chemical and Hormone Analysis (Male and Female)
- ☐ Skin Cancer
- ☐ Head and neck cancer
- ☐ Breast cancer
- ☐ Physician nutritional and supplement Counseling
- ☐ Weight Loss/Weight Management
- ☐ Advanced clinical testing for vitamin, mineral, antioxidant and/or other essential micronutrient deficiencies
- ☐ Hair Reduction
- ☐ Tattoo Reduction
- ☐ Vein Surgery
- ☐ Skin Care Products
- ☐ Injectables: Botox and Dermal Fillers

Would you like to receive promotional offer by: ☐ Mail ☐ Email