Date_____ Home Phone_____

Name_____ Cell Phone_____

Age _____ **Birthdate**_____ gender: M F Marital Status: S M D W

Email Address_____

Mailing Address_____City/State_____ Zip _____

Occupation _____ Employer Name _____

Business Address: _____ City/State _____ Zip _____

EMERGENCY Contact: _____ Phone_____Spouse/Parent/Relative

What is the reason for your visit today? _____

Who may we thank for referring you? _____

How did you hear about us? **Please check all that apply:**

□ **TV** □ **Facebook** □**Internet** □ **Google Search** □ **Lombardo Cosmetic Surgery Website** □ **Billboard** □ **Radio**

□ **CV Weekly** □ **YELP** □ **Friend or Family** □ **Gay Desert Guide**

□ **Physician Referral (name:_____)** □ **Other (please list:_____)**

What additional services would you like to learn about? Please check all that apply…

□ Botox™ □ Facial Fillers (Juvederm™, Voluma™, Restylane™, Scultpra™, Bellafill™) □ Latisse™ □ SkinMedica™ skin care products □ Regenica® skin care products □ Facial fine lines/wrinkles □ Crow's feet area □ Frown lines area	□ Length/fullness of eyelashes □ Facial fullness/drooping □ Chemical Peel □ Brown spots/age spots/freckles □ Drooping eyelids □ Weight loss □ hCG diet program	□ Breast size □ Abdominal area □ Hips □ Legs □ Arms □ Body contouring □ Scar revision □ Would you like to learn more about taking good care of your skin?

INSURANCE INFO:

Patient SSN#:_____ Primary Card Holder's SSN#_____

Primary Card Holder's Name_____

Insurance Company _____ Primary Card Holder's Birthdate_____

Insurance ID _____ Group Number _____

Do you have a primary care physician?: **Y N**

Doctor's Name: _____
Location: _____

Are you taking any Medications?: **Y N**
Please List Names & Doses _____

_____

Are you taking Aspirin, Ibuprofen or other blood thinning medications? **Y N**
_____

Are you taking Vitamins or Herbal Supplements: **Y N**
Please list Names _____

_____

Do you bleed excessively after a cut, wound or surgery? **Y N**

Have you had previous surgery?: **Y N**
List operations: _____

_____

_____

Do you have any Allergies/Sensitivities to Medications? **Y N**
Please list drug & reaction:_____

_____

Please check if you currently have or have had any of these conditions:

- □ Asthma
- □ Anemia
- □ Anesthesia related problems
- □ Anxiety/depression
- □ Arthritis
- □ Back/Neck pain
- □ Bleeding problems
- □ Blood Clots
- □ Cancer
- □ Chest Pain
- □ Chronic Cough
- □ Chronic Pain
- □ Diabetes
- □ Emphysema
- □ Glaucoma
- □ Heartburn
- □ Herpes Infection/ Cold Sores
- □ Heart Disease/Murmur
- □ High Blood Pressure
- □ HIV/AIDS
- □ Hepatitis
- □ Latex Allergy
- □ Liver Disease
- □ Jaundice
- □ Joint Replacement
- □ Kidney Disease
- □ Lung Disease
- □ Nervous Breakdown
- □ Pacemaker
- □ Seizures
- □ Stroke
- □ Stomach Ulcers
- □ TB/Tuberculosis
- □ Thyroid Disease
- □ Other:

_____

I AUTHORIZE Dr. Maria Lombardo to examine and provide Medical/Surgical Treatment. I will not record, in any way, anything which occurs in the office of Dr. Lombardo without prior written consent of Dr. Lombardo. I AGREE that I am responsible for the professional services rendered by Lombardo Surgical, Inc. & Lombardo Cosmetic Surgery. I also authorize this office to release any information necessary to process this claim.

Signature: _____ Date: _____

OFFICE USE: ☐**TY** ☐ **E-Mail Date** _____