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| Date Click here to enter text. Home Phone Click here to enter text.Name Click here to enter text. Cell Phone Click here to enter text. Age Click here to enter text. **Birthdate** Click here to enter text. gender: Click here to enter text.Marital Status: Click here to enter text.**Email Address** Click here to enter text. Mailing Address Click here to enter text.City/State Click here to enter text. Zip Click here to enter text.Occupation Click here to enter text. Employer Name Click here to enter text. Business Address: Click here to enter text. City/State Click here to enter text. Zip Click here to enter text.**EMERGENCY Contact:**  Click here to enter text. Phone Click here to enter text.Spouse/Parent/Relative |
| What is the reason for your visit today? Click here to enter text.Who may we thank for referring you? Click here to enter text.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:** Click here to enter text.**)** [ ]  **Other (please list:** Click here to enter text.**)** |

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

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| [ ]  Botox™[ ]  Facial Fillers (Juvederm™, Voluma™, Restylane™, Scultpra™, Artefill™)[ ]  Latisse™[ ]  SkinMedica™ skin care products[ ]  Facial fine lines/wrinkles[ ]  Crow’s feet area[ ]  Frown lines area | [x]  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? |

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| **INSURANCE INFO:** Patient SSN#: Click here to enter text. Primary Card Holder’s SSN# Click here to enter text. Primary Card Holder’s Name Click here to enter text.Insurance Company Click here to enter text. Primary Card Holder’s Birthdate Click here to enter text.Insurance ID Click here to enter text. Group Number Click here to enter text. |

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| Do you have a primary care physician?**:** [ ] [ ] Doctor’s Name: Click here to enter text.Location: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Are you taking any Medications?: [ ] [ ] Please List Names & Doses Click here to enter text. Click here to enter text.Are you taking Aspirin, Ibuprofen or other blood thinning [ ] [ ]  medications? Click here to enter text. Are you taking Vitamins or Herbal Supplements: [ ] [ ]  Please list Names Click here to enter text.\_Click here to enter text.Do you bleed excessively after a cut, wound or surgery? [ ] [ ] Have you had previous surgery?**:** [ ] [ ] List operations: Click here to enter text.\_Click here to enter text.\_Click here to enter text.Do you have any Allergies/Sensitivities to Medications? [ ] [ ] Please list drug & reaction:Click here to enter text.\_Click here to enter text. | **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 \_\_\_\_\_\_\_\_\_\_\_\_ Page 2/2**