

# AESTHETIC SURGERY ASSOCIATES

Patient Name: _____ # _____	What is your reason for your visit today?
Date : _____	

**Other than the services we have already provided for you, what additional services would you like to learn about? Please check all that apply**

<input type="checkbox"/> Skin care advice	<input type="checkbox"/> Botox	<input type="checkbox"/> Scars (Acne or Surgical)
<input type="checkbox"/> Skin care products	<input type="checkbox"/> Juvederm	<input type="checkbox"/> Sagging skin
<input type="checkbox"/> Longer, thicker, darker lashes	<input type="checkbox"/> Facial fine lines/wrinkles	<input type="checkbox"/> Blue/ Red leg veins
<input type="checkbox"/> Tired looking skin	<input type="checkbox"/> Thin lips	<input type="checkbox"/> Neck wrinkles
<input type="checkbox"/> Uneven skin tone	<input type="checkbox"/> Frown lines between brows	<input type="checkbox"/> Breast size
<input type="checkbox"/> Skin discoloration	<input type="checkbox"/> Lines around nose & mouth	<input type="checkbox"/> Abdominal area
<input type="checkbox"/> Blotchy skin	<input type="checkbox"/> Dark circles/ puffiness in eyes	<input type="checkbox"/> Hips
<input type="checkbox"/> Rough skin texture	<input type="checkbox"/> Facial veins	<input type="checkbox"/> Legs
<input type="checkbox"/> Facial redness	<input type="checkbox"/> Drooping brow	<input type="checkbox"/> Facial Contouring
<input type="checkbox"/> Brown spots or freckles	<input type="checkbox"/> Drooping eyelids	<input type="checkbox"/> Body Contouring
<input type="checkbox"/> Age spots	<input type="checkbox"/> Nose size or shape	<input type="checkbox"/> Unwanted Hair
<input type="checkbox"/> Red spots	<input type="checkbox"/> Facial fullness/drooping	<input type="checkbox"/> Makeup
<input type="checkbox"/> Chemical peel	<input type="checkbox"/> Mole removal	<input type="checkbox"/> Acne

**Please answer the following question on a scale of 1 to 5 by circling the appropriate number.**

When looking at my face in the mirror, I believe I look younger, the same as, or older than my true age.

<i>Younger Than</i>		<i>True Age</i>		<i>Older Than</i>
1	2	3	4	5

**How did you hear about us?**

<input type="checkbox"/> My physician	<i>Full name:</i>
<input type="checkbox"/> Magazine Ad	<i>Name:</i>
<input type="checkbox"/> Billboard	<i>Specify Ad:</i>
<input type="checkbox"/> A friend or family member	<i>Name:</i>
<input type="checkbox"/> Internet	
<input type="checkbox"/> The Physician/Practice website	
<input type="checkbox"/> Seminar	<i>Date/location:</i>
<input type="checkbox"/> Long time patient	
<input type="checkbox"/> Other	

<input type="checkbox"/> Approval to contact you regarding new products, services and special offers	<i>Best phone number to reach you:</i>
	<i>Email address:</i>

*I'm not interested in any additional services provided at this time*

↓ For Staff Use Only ↓		
<b>Physician / provider : Dr. Kevitch</b>	<b>Dr. Chung</b>	<b>Jami</b>
<i>Follow-up</i>	<i>Date</i>	<i>Completed by (name)</i>
<input type="checkbox"/> Initial Inquiry/Information Given		
<input type="checkbox"/> Contact in future – give date		
<input type="checkbox"/> Products		
<input type="checkbox"/> Free consultation		
<input type="checkbox"/> Procedure scheduled		
<input type="checkbox"/> Procedure completed		

Comments