

Patient Information as of _____ (enter today's date)
(Please Print Legibly & Fill In or Correct All Fields)

Patient's Name

_____ First Middle Last

Address _____
Street & Apt # City State Zip

Home Phone _____ Cell Phone _____ Other Phone _____

Any restrictions for contacting you? No Yes E-mail _____

May we contact you for future events, promotions, seminars, mailings, e-mails? No Yes

Age _____ Birthdate ____/____/____ SS# ____-____-____ Gender Female Male

Marital Status Single Married to: _____ Other: _____

Patient's Employer

_____ Occupation _____

Work Phone _____ Ext: _____ Is it okay to call you at work? Yes No

Address _____
Street & Suite # City State Zip

How did you hear about ?

Dr. H. Pernell (Mark all that apply)

TV News TV Ad Phone Book Magazine Newsletter Seminar Salon Web

Friend/Relative: _____ Doctor: _____ Other: _____

If you were referred by a specific person, may we thank them? Yes No

Emergency Contact

(Not in your household) _____ Relationship to Patient _____

Home Phone _____ Work Phone _____ Other Phone _____

Areas of Interest: (mark all that apply)

Facial Procedures

- Blepharoplasty (Eyelid Lift)
- Botox, Cosmetic
- Endoscopic Brow or Forehead Lift
- Earlobe Repair
- Facial Liposuction (Chin, Jowls)
- Face or Neck Lift
- Lip Enhancement/Reduction
- Otoplasty (Ear Pinning)
- Rhinoplasty (Nose Reshaping)
- Skin Resurfacing (Fraxel, Laser genesis, Chemical Peels)

Breast Procedures

- Breast Augmentation
- Breast Reconstruction
- Breast Reduction
- Mastopexy (Breast Lift)
- Nipple Reduction or Inversion

Body Procedures

- Abdominoplasty (Tummy Tuck)
- Brachioplasty (Arm Lift)
- Full Body/Buttock/Back, Thigh Lift
- Liposuction (Thighs, Abdomen, Arms, Chin)

Other Procedures

- Signature Skin Care Line/Acne Skin Care
- Velashape-cellulite reduction
- Telangectasia (facial spider veins)
- Laser Hair Removal
- Laser Tattoo Removal
- Laser Spider Leg Veins
- Lesions / Moles/Keloids-referring physicians
- △ Fillers: Radiesse, Artefill, Juvederm Plus
- △ Elos Acne Treatment
- △ Refirm, skin tightening

I am aware that my cosmetic consultation visit is complimentary. I authorize Dr. Hardaway to bill my insurance if consultation visit deems medically focused and I authorize this office to release to the named insurance company any information necessary to expedite insurance payment. I understand I am responsible for all charges, regardless of insurance coverage.

Signature _____ **Date** _____