



PATIENT INFORMATION FORM

Patient Name: _____ Sex: Female Male
Mailing Address: _____ City: _____ State: _____ Zip Code: _____
Social Security #: _____ Date of Birth: _____
Home Phone: _____ Cell Phone: _____ Other Phone: _____
Email Address: _____

*May we contact you via email for appointment reminders? Yes No
*May we email you about future promotions/discounts and/or information regarding events held by our office? Yes No

Emergency Contact: _____ Relation: _____ Phone: _____
Primary Care Provider: _____ Phone: _____ Date of Last Visit: _____

How did you hear about us?

- Google: Organic/Sponsored (Circle One)
- TV: New Day Northwest/Hallmark/Bravo/Lifetime (Circle One)
- AFPS Website
- Referral: _____
- Yahoo: Organic/Sponsored (Circle One)
- Newspaper: Korean/Chinese/Vietnamese (Circle One)
- Postcard/Flyer
- Patient: _____
- Magazine
- Other: _____

What are your primary cosmetic goals / concerns _____

What is your budget? _____ **Is surgery an option?** _____

Have you had any problems with Anesthesia in the Past: _____

Please list previous surgical operations, including procedures done for cosmetic reasons:

Procedure:		Date:	
Procedure:		Date:	
Procedure:		Date:	
Procedure:		Date:	

PATIENT HEALTH QUESTIONNAIRE

Do you or have you ever had any of the following: (Check Yes or No)					
Seizure/Epilepsy	<input type="checkbox"/> Y <input type="checkbox"/> N	Hepatitis A, B, C, D, E (circle one)	<input type="checkbox"/> Y <input type="checkbox"/> N	HIV/AIDS	<input type="checkbox"/> Y <input type="checkbox"/> N
Snoring/Sleep Apnea	<input type="checkbox"/> Y <input type="checkbox"/> N	Heartburn/Esophageal reflux	<input type="checkbox"/> Y <input type="checkbox"/> N	Cold Sores/Herpes	<input type="checkbox"/> Y <input type="checkbox"/> N
High blood pressure	<input type="checkbox"/> Y <input type="checkbox"/> N	Back pain/injury	<input type="checkbox"/> Y <input type="checkbox"/> N	Polio/Paralysis	<input type="checkbox"/> Y <input type="checkbox"/> N
High Cholesterol	<input type="checkbox"/> Y <input type="checkbox"/> N	Diabetes (Type 1 or 2)	<input type="checkbox"/> Y <input type="checkbox"/> N	Easy Bleeding/Bruising	<input type="checkbox"/> Y <input type="checkbox"/> N
Heart Failure	<input type="checkbox"/> Y <input type="checkbox"/> N	Hyperthyroidism	<input type="checkbox"/> Y <input type="checkbox"/> N	Lung disease/trouble	<input type="checkbox"/> Y <input type="checkbox"/> N
Heart Attacks	<input type="checkbox"/> Y <input type="checkbox"/> N	Hypothyroidism	<input type="checkbox"/> Y <input type="checkbox"/> N	Tuberculosis	<input type="checkbox"/> Y <input type="checkbox"/> N
Heart Murmur	<input type="checkbox"/> Y <input type="checkbox"/> N	Excessive Clotting	<input type="checkbox"/> Y <input type="checkbox"/> N	Cancer: Type	<input type="checkbox"/> Y <input type="checkbox"/> N
Asthma/Emphysema	<input type="checkbox"/> Y <input type="checkbox"/> N	Anemia	<input type="checkbox"/> Y <input type="checkbox"/> N	Other:	<input type="checkbox"/> Y <input type="checkbox"/> N



AESTHETIC FACIAL BODY PLASTIC SURGERY
DR. PHILIP A. YOUNG, MD DR. RIKESH T. PARIKH, MD

Statement of Financial Responsibility: I, the undersigned, have read the above and realize that medical and surgical charges incurred by me or my dependents for services rendered by Aesthetic Facial Plastic Surgery, PLLC are my financial responsibility. All collection fees or court fees necessary to collect this account are payable by me.

Print Patient's Name: _____

Patient's signature: _____

Date: _____