

DR. GREGORY ALBERT, M.D., P.A.

CERTIFIED BY THE AMERICAN BOARD OF PLASTIC SURGERY

PHONE: 561.495.2700 TOLL FREE: 877.3ALBERT FAX: 561.495.5826

Patient #: _____

Date: _____

DEMOGRAPHIC INFORMATION: PLEASE PRINT: *(All areas of this form are required to receive a proper evaluation)*

Last Name: _____ First Name: _____ Middle Name: _____

How do you like to be addressed? *(Circle one)* Dr. Mr. Mrs. Ms. Miss Other: _____

SSN: _____ DOB: _____ Age: _____ Marital Status: _____ Gender: Female Male

Address: _____ Apt: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

E-mail Address: _____ Occupation: _____

If a Minor, Guardian Name: _____ Relationship: _____ Contact Number: _____

MEDICAL INFORMATION:

Medical Allergies: *(List & State Reaction)*

Height: _____ Weight: _____

Social History: *(Circle & Fill in)*

Tobacco? Cigarettes Chew Pipe Snuff

Qty: _____ Never

Quit *(date)* _____

Caffeine? Never coffee/tea/soda

Alcohol? Never Rarely Social Daily

Recreational drugs? Yes No

Current Medications: *(List Name & Dosage)*

Medical History: *Do you have or have you had history of this condition? (Mark all that apply)*

Heart Disease Lung Disease Kidney Disease Liver Disease Thyroid Disease Bone/Joint Disease

High Blood Pressure Low Blood Pressure Heart Attack Asthma Diabetes Arthritis

Bruise/Bleed easily Stroke Anemia Epilepsy Immune Deficiency Rheumatism

Scarlet Fever Hay Fever Headaches Glaucoma Cold Sores Herpes

Skin Rashes Depression Alcoholism Cancer: Type _____

Other: _____

Has anyone in your family had any of the above mentioned conditions?: Yes No

Women's Health History

Pregnancies: _____ Deliveries: _____ Breast Feeding: Yes No Date of last mammogram: _____ Results: _____

Surgical History: List any previous surgeries

Type: _____ Dr.: _____ Date: _____ Side effects: _____

Type: _____ Dr.: _____ Date: _____ Side effects: _____

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HIPAA PRIVACY POLICY & PHYSICIANS RELEASE: In compliance with the federal government we endorse the patient privacy act. This act, also known as HIPAA, ensures your medical record safety, but also inhibits us from obtaining essential medical information that may affect your procedure(s)/care. This release gives our office the permission to acquire and distribute your testing and medical information. These records are shared only with essential medical personnel and the hospitals or surgical centers in which Dr. Albert is staffed. Without this release we are unable to perform any procedure(s).

OFFICE FINANCIAL POLICY: The patient is responsible for any and all charges incurred under the medical care of Gregory Albert M.D., P.A. By signing this policy I hereby waive my right to dispute a credit card charge for services rendered. There are absolutely no refunds for product(s) or service(s).

X Patient Signature: _____

Name: _____
 Patient #: _____ Date: _____

What is the reason for your visit today? _____

Today, I would also like to get additional information regarding: *(Please check all that apply)*

- | | | | | | |
|---|--|--|--|--|--|
| <input type="checkbox"/> Skin Care Advice | <input type="checkbox"/> Botox® Cosmetic | <input type="checkbox"/> Fine lines/wrinkles | <input type="checkbox"/> Tired eyes | <input type="checkbox"/> Scars (acne/surgical) | <input type="checkbox"/> Liposuction |
| <input type="checkbox"/> Brown spots/freckles | <input type="checkbox"/> Juvederm™ | <input type="checkbox"/> Laser treatments | <input type="checkbox"/> Drooping brow | <input type="checkbox"/> Blue/red leg veins | <input type="checkbox"/> Breast shape/size |
| <input type="checkbox"/> Skin texture | <input type="checkbox"/> Radiesse® | <input type="checkbox"/> Thin lips | <input type="checkbox"/> Dark circles eyes | <input type="checkbox"/> Longer lashes | <input type="checkbox"/> Abdominal area |
| <input type="checkbox"/> Chemical Peel | <input type="checkbox"/> Dysport® | <input type="checkbox"/> Frown lines | <input type="checkbox"/> Facial Aging | <input type="checkbox"/> Skin tightening | <input type="checkbox"/> Hand rejuvenation |
| <input type="checkbox"/> Facial redness | <input type="checkbox"/> Restylane® | <input type="checkbox"/> Lines around mouth | <input type="checkbox"/> Thermage | <input type="checkbox"/> Latisse® | <input type="checkbox"/> Necklift |
| <input type="checkbox"/> Obagi® | <input type="checkbox"/> ColoreScience® | <input type="checkbox"/> Fractional laser | <input type="checkbox"/> Armlift | <input type="checkbox"/> Body implants | <input type="checkbox"/> Face Lift |
| <input type="checkbox"/> Nia24® | <input type="checkbox"/> Mineral make-up | <input type="checkbox"/> Tattoo Removal | <input type="checkbox"/> Fat injections | <input type="checkbox"/> Facial implants | <input type="checkbox"/> Breast Lift |

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.

Younger than		True Age		Older than
1	2	3	4	5

How did you hear about us? (Please be as specific as possible)

- | | | | |
|--|--|-----------------|--------------------|
| <input type="checkbox"/> Newspaper | Sun-Sentinel | Palm Beach Post | Which section/day? |
| <input type="checkbox"/> Magazine | Atlantic Avenue | Simply the Best | Topic of article |
| <input type="checkbox"/> TV Commercial | Which channel, topic, during which show? | | |
| <input type="checkbox"/> News Segment | Which channel, topic? | | |
| <input type="checkbox"/> Internet | Specify site or search engine: | | |
| <input type="checkbox"/> Patient | Full Name: | | |
| <input type="checkbox"/> Physician | Full Name: | | |
| <input type="checkbox"/> Insurance | Which one: | | |
| <input type="checkbox"/> Yellow Pages | | | |
| <input type="checkbox"/> Other: | _____ | | |

APPROVAL FOR FUTURE CONTACT: YES NO

The best way to notify you of any upcoming appointments, follow-ups etc. Home Phone Cell Phone Mail E-mail

I would like to receive correspondence via e-mail (newsletters, special events, promotions etc.) YES NO

STAFF USE ONLY:	Type/Date:	By/Comment:
<input type="checkbox"/> First		
<input type="checkbox"/> Second		
<input type="checkbox"/> Third		
<input type="checkbox"/> Procedure scheduled		
<input type="checkbox"/> Notes:	_____	