POLACEK PLASTIC SURGERY

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

❑ Skin care advice	❑ BOTOX® Cosmetic	❑ Scars (Acne or Surgical)
❑ Skin care products	❑ Juvederm	❑ Sagging skin
❑ Breast size or shape	❑ Facial fine lines/wrinkles	❑ Blue/ Red leg veins
❑ Tired looking skin	❑ Thin lips	❑ Neck wrinkles
❑ Uneven skin tone	❑ Frown lines between brows	❑ Hands: age spots, etc
❑ Skin discoloration	❑ Lines around nose & mouth	❑ Abdominal area
❑ Liposuction	❑ Dark circles/ puffiness in eyes	❑ Creases beside mouth or nose
❑ Rough skin texture	❑ Facial veins	❑ Crows feet(eyes)
❑ Facial redness	❑ Drooping brow	❑ Facial Contouring
❑ Brown spots or freckles	❑ Drooping eyelids	❑ Body Skin tightening
❑ Age spots	❑ Nose size or shape	❑ Unwanted Hair
❑ Sagging arms	❑ Facial fullness/drooping	❑ Longer, thicker, darker lashes
❑ Chemical peel	❑ Mole removal	

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?

❑ My physician	*Full name:*
❑ My insurance company provider	*Name:*
❑ Internet	*Specify site or search engine::*
❑ A friend or family member	*Name:*
❑ Yellow Pages	
❑ www.polacekplasticsurgery.com	
❑ Seminar	*Date/location:*
❑ Other	

❑ Approval to contact you.	*Best phone number to reach you:*
❑ Approval to send you information on products and services (including special offers)	*Email address:*

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

↓ For Staff Use Only ↓

Physician / Provider : Dr Polocek

Follow-up	*Date*	*Completed by (name)*
❑ Initial Inquiry/Information Given		
❑ Contact in future – give date		
❑ Products		
❑ Consultation Scheduled		
❑ Procedure scheduled		
❑ Procedure completed		

Comments