LORI G. POLACEK, M.D., INC.

Patient information as of _____(today's date)

Patient Information

Patient's Name: _____
First Middle Last

Address: _____
Street & Apt# City State Zip

Home Phone:_____Cell_____Work_____

Any restrictions for contacting you? No_____ Yes_____ E-Mail_____

Our Practice would like to send special promotions to you via email—Would you like to accept these emails?
Yes_____ Opt out_____

Best Contact Method: □ Home □ Cell □ Work □ E-Mail □ Mail By checking one of the boxes for Best Contact Method, I agree to receiving correspondence

Age_____ DOB _____ Height _____ Weight _____ Gender □ Female □ Male

Patient's Employer

Employer: _____Occupation:_____

Address: _____Phone: _____

Referral Source

□ Friend/Family Member _____ □ Salon_____□ Magazine _____

□ Web Search □ Instagram □ Facebook □ Practice Website □ Event □ Walk-in □ TV AD

□TV News_____ □ Physician/Provider _____□ Other _____

Emergency Contact

Name: _____ Relationship to Patient:_____

Phone: Home_____ Cell_____ Work_____

POLACEK
Center For
Plastic Surgery
(401) 331-0202

Patient information as of _____(today's date)

Patient's Name: _____
First Middle Last

Purpose of Visit_____

_____

Previous Surgeries with Dates: (Including Cosmetic)

_____

_____

_____

Health Problems Past & Present: (Mark all that apply)

□ Diabetes □ High Blood Pressure □ Heart Problems

□ Easy Bruising □ Lung/Breathing Problems □ Bleeding/ Clotting Problems

□ Cancer □ Psychiatric/ Depression □ Other:_____

Please explain all positive responses: _____

Are you a smoker? □ Yes □ No, **How many packs a day?**_____ **Do you drink alcohol**? □ Yes □No
How many drinks per week?_____

Medications: (Include all Prescriptive, Over-The-Counter, Vitamins and Herbal medications take regularly)

_____

_____

_____

Drug or Latex Allergies: (Please indicate if none)

_____

_____

Primary Physician_____ **Phone:** _____

The above information is accurate and complete to the best of my knowledge.
I understand that office visit charges are due on the day service is rendered. Regardless of insurance coverage, all fees are considered "out of pocket". I am responsible for all bills being paid at the time of service.

Patient Signature _____**Date**_____