Ditesheim
COSMETIC SURGERY
Beyond the Before & After

Patient Registration Form

Today's Date: ________________________ *SSN:* ________________

Patient Name: ________________________ *Birth Date:* ________ *Age:* ________

Address ________________________ *Male:* _____ *Female:* _____

City, State, Zip ________________________ *Marital Status:* ___ *Married* ___ *Single* ___ *Divorced* ___ *Separated* ___ *Widow* ___ *Partner*

Home Phone: ____________ *Cell Phone:* ____________

Email: ________________________

*May we send you information by **e-mail**?* ___ *Yes* ___ *No*

May we send you information by mail? ___ *Yes* ___*No*

For privacy purposes how do you prefer to be contacted ___*Home Phone* ___*Cell Phone* ___*E-Mail* ___*Text Message* ___*Work Phone*

Patient or Parent's Employer ________________________ *Work Phone:* ________________

If patient is a student, name of school/college:
____

How were you referred to us: Please check all that apply

Internet: ☐ *Radio Station* ☐ *Station:* ________________
Google ☐ *Patient* ☐ *Name of Patient:* ________________
Doctor ☐ *Name of Doctor:* ________________
Our Website ☐ *What internet site or search engine?* ________________
Word of Mouth ☐ *Please circle: friend, relative, employee, hospital staff*
Sign on Building ☐ *Magazine* ☐ *Name of magazine:*________________
Other ☐ *Name of other source:*________________

Emergency Contact *Name:*________________ *Relationship:* ___ *Phone:* ________________

At Ditesheim Cosmetic Surgery our goal is to make any planned surgery experience as safe as possible for you. The following questions are very important in developing a surgical plan that minimizes risk and complications.

1. ***What is your current Height: ______ & Weight: _______***
2. ***Do you currently use tobacco?*** ☐ Yes ☐ No
3. ***Do you have any problems with keloid or hypertrophic scars?*** ☐ Yes ☐ No
4. ***Have you ever had any of the following cosmetic surgery?***
   ☐ ***Breast Augmentation*** ☐ ***Liposuction*** ☐ ***Tummy Tuck*** ☐ ***Facial Surgery*** (***please check all that apply)***
5. ***If so , list date of surgery and doctors name:***
   ____
6. ***Do you have children?*** ☐ Yes ☐ No ***If yes, how many and what ages:***________________
7. ***Do you have any Allergies?*** ________________________________
8. ***Do you have any Current Medical Problems that require you to see a physician on a regular basis?(ie diabetes, heart disease, high blood pressure)***________________________

By signing below I confirm all the above information is accurate to the best of my knowledge and I authorize Dr. Jeffrey A. Ditesheim and/or his associates to take my photographs for my medical record.

Signature: ________________________________ *Date:* ____________