



Patient Name:	What is your reason for your visit today?
<i>Today's Date:</i>	

Please answer the following questions 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.

<i>Younger Than</i>		<i>True Age</i>		<i>Older Than</i>
1	2	3	4	5

When looking in the mirror, I am not concerned, somewhat concerned, or very concerned about the appearance of my wrinkles.

<i>Not Concerned</i>		<i>Somewhat Concerned</i>		<i>Very Concerned</i>
1	2	3	4	5

How did you hear about us?

<input type="checkbox"/> My physician	Full name:
<input type="checkbox"/> My insurance company provider	Name:
<input type="checkbox"/> Ad (please specify ex.: yellow pages, Main Line Today, Philadelphia Magazine)	
<input type="checkbox"/> A friend or family member	Name:
<input type="checkbox"/> Internet (please specify ex.: Google, MLH website, etc.)	
<input type="checkbox"/> The Physician/Practice website	
<input type="checkbox"/> Seminar/Event	Date/location:
<input type="checkbox"/> Other	

Other than the services we have already provided for you, what additional services would you like to learn about? Please check all that apply

<input type="checkbox"/> Skin care advice	<input type="checkbox"/> Facial veins	<input type="checkbox"/> Unwanted Hair
<input type="checkbox"/> Skin care products	<input type="checkbox"/> Facial redness	<input type="checkbox"/> Mole removal
<input type="checkbox"/> BOTOX [®] Cosmetic	<input type="checkbox"/> Brown spots/age spots/freckle	<input type="checkbox"/> Scar revision
<input type="checkbox"/> Juvederm/Restylane/Radiesse	<input type="checkbox"/> Nose size or shape	<input type="checkbox"/> Acne Scarring
<input type="checkbox"/> Facial fine lines/wrinkles	<input type="checkbox"/> Facial fullness/drooping	<input type="checkbox"/> Chemical Peel
<input type="checkbox"/> Thin lips	<input type="checkbox"/> Length/Fullness of Eyelashes	<input type="checkbox"/> Other
<input type="checkbox"/> Blotchy skin	<input type="checkbox"/> Facial Contouring	

<input type="checkbox"/> Approval to contact you.	Best phone number to reach you:
<input type="checkbox"/> 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 :	CSB	LM	LG	AH	JB	SM	ER	VF	Other
<i>Follow-up</i>									
<input type="checkbox"/> Initial Inquiry/Information Given									
<input type="checkbox"/> Contact in future – give date									
<input type="checkbox"/> Products									
<input type="checkbox"/> Free consultation									
<input type="checkbox"/> Procedure scheduled									
<input type="checkbox"/> Procedure completed									

Comments