BEN HUGO, M.D., F.R.C.S.

Certified by the American Board of Plastic Surgery

WELCOME TO OUR OFFICE Date _____

Answers to the following questions will help us to provide appropriate care for your individual needs.
ALL INFORMATION IS STRICTLY CONFIDENTIAL.

Patient's Name _____

What do you prefer to be called? _____ Date of Birth _____

Address _____

City_____ State, Zip Code _____

Home Phone ( ) _____ Mobile Phone ( ) _____

Work Phone ( ) _____

At which number(s) may we leave voicemail messages? Home Mobile Work

Your Occupation _____

How did you hear of us? _____

Your Primary Physician _____

In case of emergency, whom should we contact?

Name _____

Relationship _____ Phone ( ) _____

Reason for consultation _____

Are you taking any medications? No___ Yes____ Please list _____

_____

Do you have allergies to medications? No__ Yes__ Please list medication and reaction_____

_____

_____

Have you ever responded adversely to medical or surgical treatment? No____ Yes____

If yes, please explain _____

Do you have high blood pressure, heart problems, bleeding tendency, diabetes, or asthma or any other medical problems? _____

_____

Is there anything else we should know about your state of health or medical history? _____

_____

(Women) Is there a possibility you are pregnant? No _____ Yes _____

Note: Certain medications and anesthetics should be avoided while pregnant or nursing.

PLEASE SIGN REVERSE SIDE

PLEASE READ AND SIGN

The information I have provided above is accurate and complete to the best of my knowledge.

I authorize Dr. Ben Hugo to disclose information concerning his medical findings and treatment of me, to those individuals who are required to receive such information *for the purpose of medical treatment, medical quality assurance and medical peer review.*

I understand that I am financially responsible for all charges for services rendered to me.

Patient Signature _____ Date _____

EMAIL COMMUNICATION

From time to time we like to provide information via e-mail to patients who express an interest in new developments in the fields of plastic surgery and skin care. These updates are in the form of brief newsletters, announcements or circulars and include our latest events, promotions and special pricing.

We do not share your address or personal information with persons or institutions outside of this office. You may unsubscribe and cancel these communications at any time.

If you wish to receive such information via e-mail, please complete the following:

E-mail Address (please print) _____ Patient Signature & Date _____

When you look into the mirror, what bothers you? _____

_____

COSMETIC QUESTIONNAIRE (Optional)
Procedures or products of interest to you (please check all that apply):

□ Lines/wrinkles/skin laxity
□ Brown spots/age spots/sun damage
□ Facial spider veins, capillaries
□ Eyelid wrinkles, folds, circles
□ Fillers for lines
□ Volumizers for lift: Sculptra® and Voluma®
□ Botox® Cosmetic
□ Fractional laser resurfacing of skin
□ Skin care advice/skin care products
□ Other (please specify) _____

□ Non-surgical skin tightening
□ (Mini) Face and Neck Lift
□ Non-invasive fat layer reduction (CoolSculpting®)
□ Smartlipo™ skin and tissue tightening
□ Liposuction
□ Cellulite reduction (Cellulaze™)
□ Tummy Tuck
□ Liposuction Breast Reduction
□ Breast Lift