SARATOGA SPRINGS℠ PLASTIC SURGERY, PC
Making you look and feel special

7 Wells Street, Suite 303
Saratoga Springs, NY 12866
Phone: (518) 583-4019 Fax: (518) 583-3350
www.yarinsky.com

____ New Patient Data Form ___ Updated Patient Data Form Acct. #_____

First Name:_____ Last Name:_____ Birth Date_____

Address:_____ ____ may use to contact me

_____

Name of Significant Other: _____

Please check contact preference:

Home telephone: __ __ __/__ __ __- __ __ __ __ ____may use to contact me
Work telephone: __ __ __/__ __ __-__ __ __ __ ____may use to contact me
Cell telephone: __ __ __/__ __ __-__ __ __ __ ____may use to contact me
E-Mail: _____ ____may use to contact me

Reason for visit/consultation:

_____

_____

Other Patient Interests. *Please **circle** all that apply.*

Facial Services:	**Body Contouring Services:**	**Facial/Body Services-Non-Surgical**
Face/Neck Lift	Breast Augmentation (Breast Enlargement)	Laser Hair Removal
Eyebrow/Forehead Lift	Breast Lift	Skin Care-Daily/Aging/Wrinkling
Blepharoplasty (Eyelid Lift)	Liposuction Fat Removal	Anti-aging Treatments, Face Peels
UltraPulse Laser Resurfacing	Abdominoplasty (Tummy Tuck)	Microdermabrasion
Nose Reshaping	Lipoabdominoplasty	Rosacea
Cheek/Chin Reshaping	Brachioplasty (Arm Lift)	Preventing/Reversing Sun Damage
Lip Enhancement	Inverted Nipple Correction	Age/Sun Spots, Hyperpigmentation
Ear Reshaping	Gynecomastia (Male Breast Reduction)	Facial Capillary Removal
Fat Injection – Filler	Labiaplasty	Leg Spider Veins
Face fillers-Juvéderm™	Thigh Lift	Massage/Reflexology
Restylane/Radiesse/Belotero*	Thigh/Buttock Lift	Cellulite Reduction/Endermologie/Lipomassage™
Sculptra	Tattoo Removal (by excision)	truSculpt™ Body Shaping & Fat Reduction
Botox® Cosmetic/Xeomin*		Ultherapy® Facial Skin Lifting
Scar Revision		Latisse® Eyelash Enhancement

****Non-surgical treatment administered by Board Certified plastic and cosmetic surgeon***

Who or what referred you to our practice? _____

Have you seen our: Website ____ Yellow Pages ads ____ Newspaper ads ____ Television ads ____
(check all that apply)

Where else have you heard about or obtained information on our practice? _____

Have you received mailings from us? ___Yes ___ No

Please be advised that completing preliminary health and insurance questionnaires does not establish a physician-patient relationship with this practice. Dr. Steven Yarinsky will review your health history and conduct an initial evaluation to determine whether you are a suitable candidate and whether the practice will accept you as a patient.

I acknowledge that the above information is complete and accurate, and has been provided to Saratoga Springs Plastic Surgery, P.C. for the exclusive use of the practice in serving my interests and desire for treatment by Saratoga Springs Plastic Surgery, P.C. I reserve the right to provide updated information to the practice. The practice may periodically request that I update my patient information. The above information including general health history is only for initial discovery; additional information may be requested to qualify or disqualify me as a candidate for a certain procedure(s).

Patient Signature_____ Date_____

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MEDICAL INFORMATION

Please bring on appointment date - Please print

Name:_____
Occupation:_____
Birthdate:_____Social Security No._____Today's Date:_____
Employer:_____ Employer Address:_____
Employer Phone:_____
_____

For your benefit it is necessary that you answer these questions as accurately as possible so that we can determine your physical condition before undergoing surgery.

1. DO YOU HAVE:

	YES	NO
Heart disease	___	___
High blood pressure	___	___
Diabetes	___	___
Epilepsy	___	___
Thyroid disease	___	___
Asthma	___	___

2. HAVE YOU EVER HAD:

	YES	NO
Rheumatic fever	___	___

3. DO YOU HAVE:

	YES	NO
Shortness of breath	___	___
Dizzy spells	___	___
Swelling of ankles	___	___
Chest pain	___	___
Prolonged bleeding	___	___
Jaundice	___	___
Bruise easily	___	___

4. DO YOU TAKE:

	YES	NO
Blood thinner meds	___	___
Heart medication	___	___
High blood pressure meds	___	___
Diuretic (water pill)	___	___
Daily___		
Aspirin	___	___
Diet pills	___	___

5. DO YOU TAKE OR HAVE YOU EVER TAKEN STEROIDS (CORTISONE, ETC):

YES	NO

7. LIST OPERATIONS YOU HAVE HAD AND ANY COMPLICATIONS:

_____Date_____
_____Date_____
_____Date_____
_____Date_____

8. LIST MEDICATIONS YOU TAKE: (include dosage)

_____
_____
_____
_____

9. PLEASE LIST ANY UNUSUAL MEDICAL PROBLEMS:

_____
_____
_____

10. NUMBER OF PREGNANCIES _____
Children – Age Sex

11. DO YOU SMOKE?

YES	NO
___	___

Number of packs per day _____

12. DO YOU DRINK ALCOHOL

YES	NO			
___	___	Socially___	Monthly___	Weekly___

13. HEIGHT _____ WEIGHT _____

14. DO YOU FEEL SAFE IN YOUR HOME ENVIRONMENT?

YES	NO

6. ARE YOU ALLERGIC TO:

	YES	NO
Penicillin	___	___
Local anesthetic	___	___
Other drugs (please list)_____		

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