

___ **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:

Face/Neck Lift Eyebrow/Forehead Lift
 Blepharoplasty (Eyelid Lift)
 UltraPulse Laser Resurfacing
 Nose Reshaping
 Cheek/Chin Reshaping
 Lip Enhancement
 Ear Reshaping
 Fat Injection – Filler
 Face fillers-Juvéderm™*
 Restylane*/Radiesse*/Belotero*
 Sculptra*
 Kybella*
 Botox® Cosmetic*/Xeomin*
 Scar Revision

Body Contouring Services:

Breast Augmentation (Breast Enlargement) Breast Lift
 Liposuction Fat Removal
 Abdominoplasty (Tummy Tuck)
 Lipoabdominoplasty
 Brachioplasty (Arm Lift)
 Inverted Nipple Correction
 Gynecomastia (Male Breast Reduction)
 Thigh Lift
 Thigh/Buttock Lift
 Tattoo Removal (by excision)
 Feminine Intimate Surgery –
 Labiaplasty/Hymen Repair

Facial/Body Services-Non-Surgical

Preventative and Corrective Skin Care Products/Treatments
 Laser Genesis Facial
 Microdermabrasion w/Serum Infusion
 Rosacea, Age/Sun Spots, Hyperpigmentation
 Preventing/Reversing Sun Damage
 Facial Capillary Removal
 Latisse® Eyelash Enhancement
 Ultherapy® Facial Skin Lifting
 Massage/Reflexology
 Cellulite Reduction/Endermologie/Lipomassage™
 ThermiVa Vaginal Rejuvenation
 truSculpt™ Body Shaping & Fat Reduction
 Leg Spider Veins Laser Hair Removal

**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 _____