THE LANFRANCHI CENTER
Facial Plastic Surgery & Rejuvenation

Patient Profile

Contact Information

Patient Name: _____ Today's Date: _____/_____/_____

Date of Birth: _____/_____/_____ Age: _____ Gender: ☐ Female ☐ Male

Phone Number: _____ Mobile Phone Number: _____

Email Address: _____

Mailing Address: _____

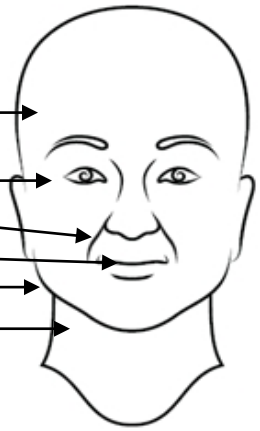
_____

Tell Us Which Area (s) Concern You Most (check all that apply)

☐ Skin/Lines

☐ Brow/Forehead

☐ Eyes: Upper/Lower
☐ Cheeks/ Nasolabial Folds
☐ Lips /Mouth
☐ Jaw Line
☐ Neck



How long have these areas been of concern to you?

_____

_____

_____

_____

We Appreciate You Choosing Us!

Who may we thank for referring you to us? _____

How did you hear about us? _____

We Appreciate You Choosing Us!

At The Lanfranchi Center for Facial Plastic Surgery & Rejuvenation we value your privacy. In order to protect the privacy of our patients it is the policy of this office to prohibit the use of sound, video and other electronic recording devices, including cell phone cameras. The use of such devices is a violation of the right to privacy of both our patients and employees. By signing below, you agree that such conduct is an invasion of the privacy of others and will refrain from using recording devices within our Center.

Agree and Acknowledge

_____ Initial — I hereby acknowledge that a copy of the Notice of Privacy Practices has been made available to me upon request and can be located online on The Lanfranchi Center website.

_____ Initial — I authorize The Lanfranchi Center for Facial Plastic Surgery & Rejuvenation to contact me or leave medical information pertaining to my care via the following methods:

Home phone and/or voicemail at: _____

Cell phone and / or voicemail/ text at: _____

Work phone and / or voicemail at: _____