Child Form

Date:_____

Under 18

CENTER FOR COSMETIC SURGERY
PATIENT INFORMATION-1/17

Please have a Parent or Guardian fill out completely and sign where indicated

Child Information

_____ _____ ____ _____ _____
Last Name (Please Print) First Name MI Pref. Name / Pronoun SSN

_____/_____/_____ _____ Sex at birth: (circle one): Male--Female _____
Date of Birth Age Gender Identity

_____
Mailing Address City State Zip Code

(_____)_____ (_____)_____ _____
Home Phone Cell Phone Email Address

Is the Child a student? (circle one) Yes No If YES name of School_____

_____ (_____)_____ (_____)_____
Primary Care Physician Phone Number Pharmacy Number OR Name/Location

Parent or Guardian Information

_____ _____ ___ _____/_____/_____
Last Name First Name MI Date of Birth

(_____)_____ (_____)_____ _____
Home Phone Cell Phone Email Address

*Preferred method of contact: (circle one) Call Cell or Home Text Email

Other Parent or Guardian Information

_____ _____ ___ _____/_____/_____
Last Name First Name MI Date of Birth

(_____)_____ (_____)_____ _____
Home Phone Cell Phone Email Address

EMERGENCY CONTACT: Please give the name of nearest relative or close friend to contact in case of an emergency:

_____ (_____)_____ (_____)_____
Name Home/ Cell Phone Work Phone

_____ _____ _____
Relationship to Patient City State

PLEASE INDICATE THE PROCEDURE(S) YOU ARE CONSIDERING:_____

_____

1. Do you have a certain time frame in mind? If so, what is that event and approximate date?_____

2. Has any major life changes occurred in the last 6-12 months? If so, explain: _____

_____

3. How did you hear about our office?_____