SHUMWAY COSMETIC SURGERY

A Professional Medical Corporation
Robert A. Shumway, MD, FACS

PATIENT INFORMATION SHEET

Last Name: _____ First Name:_____ Date of Birth: _____

Address:_____ Cell Phone: _____

City: _____ Work Phone: _____

State:_____ Zip Code_____ Home Phone:_____

Email:_____ Emergency Contact Name: _____

Occupation:_____ Emergency Contact Phone #: _____

Please list the procedure(s) you are interested in learning more about or describe your cosmetic goals.

1._____ **2.**_____
3._____ **4.**_____

Health History

Please list all past surgeries and treatments:

Type: _____ Year: _____

Type: _____ Year: _____

Type:_____ Year:_____

Type:_____ Year:_____

Allergies (please list): _____

Current Medications: _____

Do You: □ Smoke □ Drink Alcohol □ Take Vitamins □ Take Vitamin E □ Take Ibuprofen Products
□ Take Blood Thinners □ Get Cold Sores □ Take Fish Oil

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How do you plan to pay for your procedure? □Cash □Cashier's Check □Credit Card □Financing **Sorry No Personal Checks.**

How did you hear about us? □ Radio □ Pandora □ Google □ Yelp □ Facebook □ Twitter □ Patient Referral □ Other :_____

Please acknowledge receipt of the following forms by signing below: HIPPA, Arbitration, Infection Control Processes, Credentials and Patients Rights/Grievences:

Patient Signature:_____ Date:_____

9834 Genesee Avenue, Suite 225, La Jolla, CA 92037 Phone (858) 587-2640 Fax (858) 587-9870