Foundation For Hair Restoration
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Locations: Miami, NYC, Boca Raton, and Tampa

PATIENT INFORMATION FORM

Name ____ **Date** ______________________

Address (Permanent) ____
City/State **Zip code**

Address (Local) ____
City/State **Zip code**

Home Phone _____________________ **Cell Phone**__________________________________

Date Of Birth ______________ **Age** _____ **Social Security No.** _____________________

Name Of Spouse/Partner ____________________ **E-Mail** ___________________________

Referred By ______________________________________

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Occupation ________________________ **Employed By** ____________________________

Business Address ____
City/State **Zip Code**

Bus. Phone ___________________________

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If Minor, Person Who Is Legally Responsible ______________________________________

As you know, some types of surgery are not covered by insurance. However, the following information is important to have on file.

Name Of Insurance ____

Address ____
City/State **Zip code**

Phone ________________________ **Effective Date**_______________________________

I.D. No. ________________________ **Group No.** __________________________

Name Of Personal Physician ____

Reason For Your Visit ____

Preferred Method Of Payment (please circle) :

Credit Card **Cash** **Check** **Insurance (if applies)** **Financing Plan**

MEDICAL HISTORY

Allergies To Medications ____

Allergies/Sensitivities To Latex, Tape, Iodine, Etc. ____________________________

Current Medications ____

Current Vitamins, Holistic Medications ____________________________________

Past Surgeries, Including Plastic Surgery (include location, approximate dates)

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History Of Any Serious Illness Or Accidents __________________________________

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Have You Ever Had Any Of The Following Problems? (please circle if yes)

Anemia **Bleeding** **Complications with Anesthesia**

Diabetes **Easy Bruising** **High Blood Pressure**

Jaundice/Hepatitis **Mitral Valve Prolapse**

Poor Healing/Scarring **Psychological (consulting a professional)**

Respiratory/Asthma **Substance Abuse**

If You Circled Any Of The Above, Please Describe __________________________

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Do You Have Any Of The Following Habits?

Cigarette/Cigar Smoking ____________ **Frequency** ____________________

Alcohol __________________________ **Frequency** ____________________

Have You Been Told You Need Antibiotics Prior To Surgery? __________________

____________________	__________	______________________	____________
Doctor's Signature	**Date**	**Patient's Signature**	**Date**