

Patient Information

Patient Name: _____

Date of Birth: ____/____/____ Age: _____

Height: _____ Weight: _____

Address: _____

Home Phone: _____

Work Phone: _____

Cell Phone: _____

Date of Scheduled Appointment: ____/____/____

What areas of your body do you want liposuctioned:

Have you had any prior surgeries: Yes No

If yes, please list: _____

If surgery could be performed, how soon would you like to have it done:

one week two weeks one month two months within 6 months

If your were referred, by whom: _____

▶ _____ / ____ / ____

Patient's Signature

Date