GARLICH FACIAL PLASTIC SURGERY

Patient Name: **What is your reason for your visit today?**

Date :

Help us better serve you.
What services would you like to learn about?
Please check **all** that apply.

❑ Skin Care Advice	❑ Facial Veins	❑ Neck Wrinkles
❑ Skin Care Products	❑ Facial Redness	❑ Facial Contouring
❑ Injectable Treatments	❑ Brown Spots/Age Spots/Freckle	❑ Protruding Ears (adult / child)
❑ Juvederm/Restylane/Radiesse	❑ Drooping Brow or Eyelids	❑ Eyebrow Shaping
❑ Facial Fine Lines/Wrinkles	❑ Nose - size or shape	❑ Length/Fullness of Eyelashes
❑ Thin Lips	❑ Facial Mole Removal	❑ *Jane Iredale* Mineral Makeup
❑ Blotchy Skin	❑ Facial Fullness/Drooping	❑ Proper Make-up Application
❑ Unwanted Body Hair	❑ Facial Scar Revision	❑ Hosting an Event
❑ Medical-Grade Facials	❑ Earlobe (Stretch / Rip from piercing)	❑ Current Specials

Please answer the following questions on a scale of 1 to 5 by circling the appropriate number.
When looking at my face in the mirror, I believe I look younger, the same as, or older than my true age.

Younger Than		*True Age*		*Older Than*
1	2	3	4	5

When looking in the mirror, I am not concerned, somewhat concerned, or very concerned about the appearance of my wrinkles.

Not Concerned		*Somewhat Concerned*		*Very Concerned*
1	2	3	4	5

How did you hear about us?

❑ My physician	*Full name:*
❑ My insurance company provider	*Name:*
❑ The yellow pages	*Specify Ad:*
❑ A friend or family member	*Name:*
❑ Internet	
❑ The Physician/Practice website	
❑ Seminar	*Date/location:*
❑ Other	

❑ Approval to contact you.	*Best phone number to reach you:*
❑ Approval to send you our monthly E-Newsletter containing specials, wellness/beauty information, upcoming events, and more.	*Email address:*

↓ For Staff Use Only ↓

Physician / Provider / Staff : Dr. Garlich Faith Donna Rena

Follow-up	*Date*	*Completed by (name)*
❑ Initial Inquiry/Information Given		
❑ Contact in future – give date		
❑ Products		
❑ Free consultation		
❑ Procedure scheduled		
❑ Procedure completed		