Donald R. Collins, Jr., MD, FACS

Aesthetic Plastic Surgery

Name_____

Last First Middle

Address _____

Street City State Zip code

Cell Phone _____ Home Phone _____ Other Phone_____

Email Address _____

Birthdate _____/_____/_____ Age _____ ☐ Female ☐ Male

Marital Status _____ Referred by _____ Primary Care Physician _____

Occupation _____

Emergency Contact _____ Relationship to patient _____

Cell Phone _____ Home Phone _____ Other Phone_____

Medical Information

Reason for consultation _____

_____

Height _____ Weight _____

Serious Illnesses _____

_____

Previous Surgeries _____

_____

Current Medications _____

_____

Drug Allergies _____

Pharmacy _____ Phone number _____

Hereditary disorders _____

Do you take aspirin? ☐ yes ☐ no How often? _____

Do you smoke? ☐ yes ☐ no How long and how much?_____

Do you drink? ☐ yes ☐ no How long and how much?_____

Do you or have you used illicit drugs? ☐ yes ☐ no How long and how much?_____

I understand that office visit charges are payable on the day services are rendered.

_____ _____

Signature Date