NORFOLK PLASTIC SURGERY, PC (757) 466-1000

□ Lawrence B. Colen, M.D., F.A.C.S. □Theodore W. Uroskie, Jr., M.D., F.A.C.S. (Please print legibly. Complete all blanks and make any necessary corrections)

Patient's Name _____
Last First Middle

Address _____
Street & Apt # City State Zip

Home Phone _____ Cell Phone _____ Other Phone _____

Any restrictions for contacting you? ❒ No ❒ Yes

Would you like to be included in our e-mail newsletter? ❒ Yes ❒ No

E-mail address: _____

Contact Restrictions: _____

Age _____ Birthdate _____ SS# _____ Gender

Marital Status **Spouse's Name:** _____ Spouse's Wk. Phone _____

Patient's Employer _____ Occupation _____

Work Phone _____ Ext: _____ Is it okay to call you at work? ❒ Yes ❒ No

Address _____
Street & Suite # City State Zip

Emergency Contact
(Not in your household) _____ Relationship to Patient _____

Home Phone _____ Work Phone _____ Other Phone _____

Address _____
Street & Apt # City State Zip

Is This Visit Cosmetic Medical or Both (If insurance needs to be billed, please provide a copy of your insurance cards)

Cosmetic Concern: _____

WHAT IS YOUR PRIMARY COSMETIC CONCERN?: _____

Have You Had Previous Cosmetic Surgery? Yes No

If Yes, List Procedures Below:

_____ Date:_____

_____ Date: _____

Do you have Children? Yes No If yes, what are their ages?_____

How did you hear about our office?: _____

Please list name if applicable: _____

Do you currently use skincare products? Yes No List: _____

I verify that I have reviewed the above information and made any corrections that are necessary. I authorize the practice to bill my insurance company (if applicable). I understand that cosmetic surgical fees are due two weeks in advance unless otherwise indicated. I understand that pre and post operative photos will be taken for my medical record. Additionally, I consent or do not consent to the use of my photos for review by other patients considering surgery as indicated below .

I consent to the release of my photos **without any exception**. YES NO

I consent to the release of my photos ONLY **as indicated below**:

Yes No NA The release of photos of **my body excluding my face (**upper or lower body procedures, breast procedures, limbs, etc) .

Yes No NA The release of photos that include **my full face**.

Yes No NA The release of photos that include **partial disclosure of my face**.(Limited to the treatment area only ie: eyes, lips, nose, etc.)

Signature _____ **Date** _____