Orange County Plastic Surgery
Medical Associates Inc.
Specializing in Cosmetic Surgery

PATIENT INFORMATION

Name_____Date_____

Age_____Height_____Weight_____DOB_____

Address_____

City_____ State _____ Zip Code_____

Phone Number _____ May we text you? Yes/No

Alternative Phone _____ May we leave a message? Yes/No

E-Mail_____ May we send you information in the future? Yes/No

Occupation _____ Employer_____

Spouse/Responsible Party _____

Personal Physician _____

Referral Source _____May we thank them for referral? Yes/No

How may we help you? _____

Would you say you enjoy good health?_____Illnesses_____

Operations/Dates _____

Serious Family Illnesses _____

Number of Children _____ Family History of Breast Cancer _____

Are you taking or have you taken:	Yes	No
Cortisone, steroids, ACTH		
Anticoagulants or blood thinners		
Tranquilizers or sedatives		
Digitalis or diuretics		
Insulin		
Any other medicines or drugs:		
_____		

Are you sensitive or allergic to:	Yes	No
Penicillin		
Novocain or any local anesthetic		
General anesthetic		
Other		

Have you ever had any of the following:	Yes	No
Cancer		
Heart trouble		
High or low blood pressure		
Dizziness, ear trouble		
Epilepsy		
Sinus, hay fever or asthma		
Kidney or bladder trouble		
Diabetes		
Anemia, blood clots, phlebitis		
Hepatitis, HIV infection		
Body Dysmorphic Syndrome		
Alcoholism, drug abuse		

Do you smoke? Yes__No__ Quit Date: _____
How much?_____

Other than the services we have already provided for you, what additional services or procedures would you like to learn about? Please check all that apply.

❑ Skin care advice	❑ Facial rejuvenation	❑ Breast size
❑ Skin care products	❑ Facial redness/veins	❑ Breast drooping
❑ Facial Injectables/ Fillers	❑ Brown/Age spots/freckles	❑ Abdominal area
❑ Facial fine lines/wrinkles	❑ Drooping brow	❑ Hips
❑ Thin lips	❑ Drooping eyelids	❑ Legs
❑ Eyelashes	❑ Nose size or shape	❑ Facial Contouring
❑ Chemical peel	❑ Facial fullness/drooping	❑ Body Contouring
❑ Blotchy skin	❑ Mole removal	❑ Unwanted Hair

❑ Non-Surgical radiofrequency skin tightening or fat removal

FOR WOMEN ONLY (Please answer the following questions by encircling what most appropriately applies to you)

❑ ThermiVa Consultation ☐ Vaginal Looseness ☐ Enlarged Labia

PERMISSION FOR PHOTOGRAPHY

I HEREBY GIVE PERMISSION TO JURIS BUNKIS, M.D. TO TAKE NECESSARY CLINICAL PHOTOGRAPGHS OF _____ WITH THE UNDERSTANDING THAT SUCH PHOTOGRAPHS ARE CONFIDENTIAL AND THE REMAIN THE PROPERTY OF JURIS BUNKIS, M.D.

OCCASIONALLY SUCH PHOTOGRAPGHS ARE USED FOR TEACHING PURPOSES AND FOR ETHICAL SURGICAL PUBLICATIONS, INCLUDING THE INTERNETT, FOR THE ADVANCEMENT OF SURGICAL KNOWLEDGE. YOUR IDENTITY IS ALWAYS PROTECTED.

PLEASE "X" ONE

I WILL _____ OR I WILL NOT _____ PERMIT THE USE OF MY PHOTOGRAPGHS FOR SUCH ETHICAL PROFESSIONAL PURPOSES.

SIGNED_____ DATE _____

1. *When looking at my face in the mirror, I believe I look: **younger, the same as, or older** than my true age.*
2. *When looking in the mirror, I am: **not concerned, somewhat concerned, or very concerned** about the appearance of my face/nose/ears, etc.*
3. *When looking in the mirror, I am: **not concerned, somewhat concerned, or very concerned** about the appearance of my body/breasts, tummy, etc.*

ACKNOWLEDGEMENT OF PATIENT PRIVACY RULES

Orange County Plastic Surgery does not divulge or disclose any patient information including patient's privacy rights.

Signature of Patient: _____ **Date**: _____

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