THE MYERS INSTITUTE OF PLASTIC & HAND SURGERY

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Gadsden, AL 35903
256-494-8000 Phone
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COSMETIC CONSULTATION FORM

(Please Print)

PATIENT INFORMATION

Last Name:	First Name:	Middle Name:	Date of Birth:
			/ /

Reason for Visit

Explain:

Please indicate which procedures you are interested in discussing with Dr. Myers:

Botulinum Toxin	Dermal Fillers			Deoxycholic Acid
❑ Botox® ❑ Dysport®	❑ Juvéderm Voluma® Xc ❑ Juvéderm® Xc ❑ Juvéderm® Ultra Xc ❑ Juvéderm Volbella® Xc	❑ Restylane® Lyft ❑ Restylane® ❑ Restylane® Defyne ❑ Restylane® Refyne	❑ Restylane® Silk	❑ Kybella®

Surgical Consultation

❑ Face/Neck Lift ❑ Forehead Lift ❑ Eyelid Surgery ❑ Lip Enlargement	❑ Breast Reduction ❑ Breast Reconstruction ❑ Breast Lift ❑ Breast Enlargement	❑ Liposuction ❑ Abdominal Tightening ❑ Body Contouring	❑ Thigh Lift ❑ Arm Lift ❑ Other

BREAST CONSULTATION PATIENTS ONLY

Current bra size:	Desired bra size:	Is one breast larger than the other? ❑ NO ❑ YES

Do you have any problems associated with large breasts? (rash, back pain, shoulder strap indentations, etc.) ❑ NO ❑ YES

If YES, please explain

Date of last mammogram: / /	Where was the last mammogram done?
Have you had breast cancer? ❑ NO ❑ YES	Have any family members had breast cancer? ❑ NO ❑ YES
Do you have pain in your breast? ❑ NO ❑ YES	Do you have drainage from your nipples? ❑ NO ❑ YES
Do you have fibrocystic breast disease? ❑ NO ❑ YES	Do you have nipple sensation? ❑ NO ❑ YES
Have you felt any lumps or masses in your breasts? ❑ NO ❑ YES	If you have children, did you breastfeed? ❑ NO ❑ YES

Have you had any surgeries or biopsies on your breast? ❑ NO ❑ YES If YES, list date and location:

I verify that the above information is factual and true to the best of my knowledge. I authorize the doctor to employ X-rays, photographs, anesthetics, medicines, surgeries, and other equipment or aids as he deems necessary in order to provide the proper patient care. I understand that payment, proof of insurance, and/or copay is due at the time of service.
I authorize this office to apply benefits on my behalf for the covered services rendered. I certify that the insurance information I have provides is factual and correct.

Patient or Guardian Signature	Date