



NEWPORT FACES
COSMETIC SURGERY

PATIENT INFORMATION

LAST NAME _____ FIRST NAME _____

DATE OF BIRTH _____

ADDRESS _____

CITY _____ STATE _____ ZIP CODE _____

EMAIL ADDRESS _____

HOME # _____ MOBILE # _____

OCCUPATION _____ WORK # _____

EMPLOYER _____

WHO MAY WE THANK FOR REFERRING YOU TO US ? _____

EMERGENCY CONTACT:

LAST NAME _____ FIRST NAME _____

MOBILE # _____

The above information is true and correct to the best of my knowledge. I give my consent to Dr. Stephen H. Fink to provide medical consultation and or treatment. I understand I am responsible for charges incurred. I authorize Dr. Stephen H. Fink to take and use my photos for professional-medical purposes. Including but not limited to patient education, electronic digital and video for education purposes, lay publication, advertising, print advertising, website or social media. I authorize Dr. Stephen H. Fink to obtain my medical records as needed for my treatment and care.

Patient Signature: _____ Date: _____

Print Name: _____

PATIENT MEDICAL HISTORY

Are you pregnant or nursing?	Y/N	Liver insufficiency, Cirrhosis or active Hepatitis?	Y/N
Are you currently undergoing radiation therapy or chemotherapy?	Y/N	Blood clots or Pulmonary Embolism?	Y/N
Have you ever had a connective tissue disorder such as Ehlers Danlos Syndrome, Lupus, Scleroderma, Rheumatoid Arthritis, Wegener's Disease, or Sarcoidosis?	Y/N	Diabetes that requires medication?	Y/N
Have you had surgery of the face or neck within the previous 6 months?	Y/N	High Blood Pressure (Hypertension)?	Y/N
Bleeding Disorder?	Y/N	Heart Disease or heart problems?	Y/N
Abnormal Scarring?	Y/N	Do you have a pacemaker or AICD?	Y/N
Allergy or reaction to latex?	Y/N	Oxygen dependent COPD or severe asthma?	Y/N
Lidocaine allergy?	Y/N	Have you ever had a stroke or TIA?	Y/N
Epinephrine sensitivity?	Y/N	Are you a current smoker?	Y/N
Prior parotidectomy (salivary gland removal)?	Y/N	Do you consume alcohol? If yes, how often? Weekly/Social/Occasionally (circle)	Y/N
Obstructive Sleep Apnea?	Y/N	Severe dry eyes?	Y/N
Are you currently under a pain contract?	Y/N	Do you take medical marijuana, how often?	Y/N

If you answered yes to any of the above questions, please provide details below:

Please list all previous surgeries: _____

Please list all medications and dosages:

Please list all allergies:

Is there anything else Dr. Fink should know regarding your health?:

Name of your Physician: _____ Phone Number: _____

I certify that all information I have listed above is accurate and complete to the best of my knowledge.

Signature: _____ Print Name: _____ Date _____

Dr. Signature: _____ Date: _____

