



DR. PHILIP A. YOUNG, MD  
AESTHETIC FACIAL PLASTIC SURGERY

**PATIENT INFORMATION FORM**

Legal Name: \_\_\_\_\_ Sex:  Female  Male  
Mailing Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
Occupation: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Other Phone: \_\_\_\_\_  
EmailAddress: \_\_\_\_\_

\*May we contact you via email for appointment reminders?  Yes  No  
\*May we email you about future promotions/discounts and/or information regarding events held by our office?  Yes  No

Emergency Contact: \_\_\_\_\_ Relation: \_\_\_\_\_ Phone: \_\_\_\_\_  
Primary Care Provider: \_\_\_\_\_ Phone : \_\_\_\_\_ Date of Last Visit: \_\_\_\_\_

**How did you hear about us?**

- Google: Organic/Sponsored (Circle One)  Yahoo: Organic/Sponsored (Circle One)
- TV: New Day Northwest/Hallmark/Bravo/Lifetime(Circle One)  Newspaper: Korean/Chinese/Vietnamese (CircleOne)
- AFPS Website  Postcard/Flyer  Magazine
- Referral: \_\_\_\_\_  Patient: \_\_\_\_\_  Other: \_\_\_\_\_

**What are your primary cosmetic goals / concerns** \_\_\_\_\_

**How long have you been thinking about these procedures:** \_\_\_\_\_

**What date did you have in mind for your procedures:** \_\_\_\_\_

**How long have you been researching our Team or Doctor:** \_\_\_\_\_

**Who do you have that can take care of you after your procedure & that can support you through the recovery (family or friends):** \_\_\_\_\_

**Tell us something personal about you that you would like to share:** \_\_\_\_\_

| Do you or have you ever had any of the following: (Check Yes or No) |   |   |                                      |                        |   |   |
|---------------------------------------------------------------------|---|---|--------------------------------------|------------------------|---|---|
| Seizure/Epilepsy                                                    | Y | N | Hepatitis A, B, C, D, E (circle one) | Y                      | N |   |
| Snoring/Sleep Apnea                                                 | Y | N | Heartburn/Esophageal reflux          | Y                      | N |   |
| High blood pressure                                                 | Y | N | Back pain/injury                     | Y                      | N |   |
| High Cholesterol                                                    | Y | N | Diabetes (Type 1 or 2)               | Y                      | N |   |
| Heart Failure                                                       | Y | N | Hyperthyroidism                      | Y                      | N |   |
| Heart Attacks                                                       | Y | N | Hypothyroidism                       | Y                      | N |   |
| Heart Murmur                                                        | Y | N | Excessive Clotting                   | Y                      | N |   |
| Asthma/Emphysema                                                    | Y | N | Anemia                               | Y                      | N |   |
|                                                                     |   |   |                                      | HIV/AIDS               | Y | N |
|                                                                     |   |   |                                      | Cold Sores/Herpes      | Y | N |
|                                                                     |   |   |                                      | Polio/Paralysis        | Y | N |
|                                                                     |   |   |                                      | Easy Bleeding/Bruising | Y | N |
|                                                                     |   |   |                                      | Lung disease/trouble   | Y | N |
|                                                                     |   |   |                                      | Tuberculosis           | Y | N |
|                                                                     |   |   |                                      | Cancer: Type           | Y | N |
|                                                                     |   |   |                                      | <b>Other:</b>          | Y | N |





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Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone #: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone #: \_\_\_\_\_

**Statement of Financial Responsibility:** I, the undersigned, have read the above and realize that medical and surgical charges incurred by me or my dependents for services rendered by Aesthetic Facial Plastic Surgery, PLLC are my financial responsibility. All collection fees or court fees necessary to collect this account are payable by me.

Print Patient's Name: \_\_\_\_\_

Patient's signature: \_\_\_\_\_ Date: \_\_\_\_\_