

John A.D. Ward M.D., F.A.C.S
DIPLOMATE AMERICAN BOARD OF PLASTIC SURGERY
AESTHETIC PLASTIC SURGEON

Please Print Legibly & Fill In or Correct All Fields

Date: _____ E-mail _____
(For our newsletter and specials)

New Patient Returning Patient Last date of Surgery with Dr. Ward _____

Patient's Name _____
First Middle Last

Address _____
Street & Apt # City State Zip

Home Phone _____ Cell Phone _____ Other Phone _____

Any restrictions for contacting you? No Yes

Contact Restrictions: _____

Age _____ Birthdate / / SS# = = Gender Female Male

Marital Status Single Married to: _____ Other: _____

Patient's Employer _____ **Occupation** _____

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

How did you hear about Dr. Ward? (Mark all that apply)

Friend/Relative: _____ Doctor: _____ Website _____

Other: _____

Emergency Contact: _____ () _____ Relationship to patient _____

Areas of Interest: (mark all that apply)

Facial Procedures

- Face or Neck Lift
- Facial Liposuction (Neck)
- Brow or Forehead Lift
- Blepharoplasty (Eyelid Lift)
- Chin Augmentation
- Otoplasty (Ear Pinning)
- Rhinoplasty (Nose Reshaping)
- Skin Resurfacing (Laser, Peel, Etc.)

Breast Procedures

- Breast Augmentation
- Breast Reduction
- Mastopexy (Breast Lift)

Body Procedures

- Abdominoplasty (Tummy Tuck)
- Brachioplasty (Arm Lift)
- Full Body Lift
- Liposuction (Thighs, Abdomen, Etc.)
- Thigh or Buttock Lift

Other Procedures

- Botox / Dysport
- Lesions / Moles
- Lip Enhancement
- Wrinkle Fillers (injections)

I understand that office visit charges are payable on the day service is rendered.

Signature _____ Date _____

Patient's Name _____
First Middle Last

Purpose of Visit: _____

Previous Surgeries with Dates: (Including cosmetic)

Health Problems Past & Present: (mark all that apply)

- Allergies
- Arthritis
- Asthma
- Diabetes
- Heart Attack/Stroke
- Hepatitis
- Leukemia
- Migraines
- Stomach Ulcers/Colitis

- Bleeding/Clotting Problems
- Depression
- Other: _____
- High Blood Pressure
- Kidney Disease
- Thyroid

Do you smoke? No Yes, How many packs a day? _____

Medications you are taking: (include all Prescriptive, Weight Reduction pills, Hormones, Birth Control method, Over-The-Counter, Vitamins and Herbal medications taken regularly)

Drug or Latex Allergies: (please indicate if none)

Codeiene _____ Aspirin _____ Penicillin _____ Sulfa _____

Erythromycin _____ None Known _____ Iodine _____ Latex _____

Primary Physician _____ Phone _____

Date of Last Physical: _____ Mammo: _____ Chest X-Ray: _____

The above information is accurate and complete to the best of my knowledge. I understand that I am responsible for payment in FULL for Cosmetic Surgery to Dr. Ward 3 weeks prior to surgery date. If for any reason additional fees are required due to more surgical time needed and/or a medical emergency to a Hospital facility, I am responsible

for payment regardless of insurance.

Signature _____ Date _____