

# 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)

### Other Procedures

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

### Body Procedures

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

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)

Codeine \_\_\_\_\_ 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** \_\_\_\_\_