

Lee D. Robinson, M.D., P.C.

Facial Plastic & Reconstructive Surgery

PATIENT INFORMATION FORM

Your answers will remain confidential, as will all other aspects of your association with this office and members of our staff.

Name: _____

Date of Birth: _____ Age: _____ Sex: _____ SS#: _____

Home Address: _____

City: _____ State: _____ Zip: _____

Phone: Home () _____ Daytime () _____ Cell () _____

E-mail address: _____

Please check below your preference for method(s) of contact.

Home Phone _____ Day Phone _____ Cell Phone _____ E-mail _____ Mail _____

Marital Status: () Single () Married () Separated () Divorced () Widowed

Occupation: _____

Name of Spouse/Partner: _____ Number of Children: _____

Emergency Contact: _____ Phone #: () _____

How were you referred to Dr. Robinson? _____

Reason for Appointment: _____

Medication(s), Amounts & Frequency: _____

List all drug allergies: _____

Have you ever been diagnosed with a blood born illness? Yes No

If yes, circle all that apply: HIV Hepatitis Immuno-compromised

Other: _____

Do you tan on a regular basis? Yes/No

Do you have recurrent fever blisters, herpes or cold sores? Yes/No

Are you a smoker? Yes/No Ex-Smoker? Yes/No

Is there any possibility that you are pregnant at this time? Yes/No

List all surgeries that you have had, including plastic surgery: _____

I am interested in remaining on a patient contact list of Dr. Lee Robinson and receiving information on upcoming new services, newsletter and other information on cosmetic surgery that might benefit me or my family. Yes _____ No _____

Signature _____ Date _____