

# Parvaiz Malik MD F.A.C.S.

Plastic Surgery of Central Jersey, P.C.

## COSMETIC

Date \_\_\_\_\_

[PLEASE PRINT CLEARLY]

### PATIENT INFORMATION

First Name \_\_\_\_\_ Initial \_\_\_\_\_ Last Name \_\_\_\_\_

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Sex: M / F Marital Status: M S D W

Social Security # \_\_\_\_\_

Race \_\_\_\_\_ Nationality \_\_\_\_\_ Language \_\_\_\_\_

Home Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Home Phone \_\_\_\_\_

Cell Phone \_\_\_\_\_

Work Phone \_\_\_\_\_

Preferred Contact: Home Cell Work Email

Email Address \_\_\_\_\_ Occupation: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Relation: \_\_\_\_\_ Phone: \_\_\_\_\_

How did you hear about Dr. Malik?

Doctor Friend/Family Internet/Website Name of Referrer: \_\_\_\_\_

### REASON FOR VISIT:

Other Concerns / Areas of Interest: (check all that apply)

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Forehead Lines     | <input type="checkbox"/> Thin Lips             | <input type="checkbox"/> Skin Fillers/Plumpers |
| <input type="checkbox"/> Frown Lines        | <input type="checkbox"/> Jowls                 | <input type="checkbox"/> Face Lift             |
| <input type="checkbox"/> Crows Feet         | <input type="checkbox"/> Sun Damage            | <input type="checkbox"/> Neck Lift             |
| <input type="checkbox"/> Low Eyebrows       | <input type="checkbox"/> Brown Spots           | <input type="checkbox"/> Cheek Lift            |
| <input type="checkbox"/> Droopy Eyelids     | <input type="checkbox"/> Fine Lines / Wrinkles | <input type="checkbox"/> Eyelid Lift           |
| <input type="checkbox"/> Excess Eyelid Skin | <input type="checkbox"/> Skin Cancer           | <input type="checkbox"/> Brow lift             |
| <input type="checkbox"/> Under Eye Bags     | <input type="checkbox"/> Sun Protection        | <input type="checkbox"/> Lip Augmentation      |
| <input type="checkbox"/> Under Eye Darkness | <input type="checkbox"/> Excessive Sweating    | <input type="checkbox"/> Lip Lift              |
| <input type="checkbox"/> Angry / Tired Look | <input type="checkbox"/> Scarring              | <input type="checkbox"/> Facial Implants       |
| <input type="checkbox"/> Sunken Cheeks      | <input type="checkbox"/> BOTOX Cosmetic®       | <input type="checkbox"/> Fat Transfer          |

\_\_\_\_\_  
Signature Patient / Parent / Guardian