

Parvaiz Malik MD F.A.C.S.

Plastic Surgery of Central Jersey, P.C.

PERMANENT MAKEUP

Date _____

[PLEASE PRINT CLEARLY]

PATIENT INFORMATION

First Name _____ Initial _____ Last Name _____

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

Race _____ Nationality _____ Language _____

Home Address _____

City _____ State _____ Zip Code _____

Home Phone _____ Cell Phone _____ Profession _____

Work Phone _____ XT _____ Preferred Contact: Home Cell Work Email

Email Address _____ Is it ok to call you at work? Yes / No

Emergency Contact: _____ Relation: _____ Phone: _____

How did you hear about our office?

Doctor Friend/Family Internet/Website Name of Referrer: _____

REASON FOR VISIT _____

Do you or any family member suffer from any of the following:

- | | |
|------------------------------------|--|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> High Cholesterol |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Infectious Diseases |
| <input type="checkbox"/> Epilepsy | |

Are you currently taking any medications? Yes / No If so, please list them _____

Have you had any surgeries? Yes / No If so what kind and how long ago? _____

Have you had any Cosmetology treatments? Yes / No If so what kind and how long ago? _____

I declare that I came to this office of my own free will to have cosmetic procedures performed. I understand that I will not receive a consultation or treatment by a physician. An experienced operator in micro-pigmentation will do this work. I also understand that I must follow the instructions given regarding aftercare following my procedure. I understand and accept responsibility that if I don't follow the instructions indicated to me complications can result.

Signature: _____

Patient / Parent / Insured / Guardian