Kimberly K. Short, M.D F.A.C.S.

PATIENT INFORMATION FORM

Patient Account #:_____
(For office use only)

First: _____ Middle Initial: ____ Last Name: _____

Home Address: _____ Apt#: _____ City: _____ St: _____ Zip: _____

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

Date of Birth: _____ Age: _____ Social Security Number: _____

May We E-mail You? Yes or No If So, Email Address _____

Marital Status: *M S D W (circle one)* ***Gender****: Male/Female (circle one)*

Patient's Employer: _____ Phone: ( ) _____

Emergency Contact: _____ Relationship: _____ Phone: ( ) _____

PLEASE CIRCLE ANY AREAS OF INTEREST YOU MAY HAVE

Breast Enlargement/Lift	Breast Reduction	Tummy Tuck	Liposuction	Buttock Augmentation
Thigh/Buttock Lift	Nose Surgery	Eyelid Surgery	Face Lift/ Neck Lift	Ear Surgery
Browlift	BOTOX	Laser Skin Resurfacing	Laser Hair Removal	Microdermabrasion
Artefill	Radiesse	Restylane/Perlane	Juvederm Ultra/Plus	Prevelle
Fat Grafting	TCA Peel	Skin Care	Vascular Lesions	Varicose Veins
Lipolysis/Mesotherapy (Fat Dissolving)	Weight Loss/Wellness Program	Profractional/BBL Laser	Skin Tyte/Thermage	Permanent Make-up

May we send you information on the above? Yes or No May we send you our news letter? Yes or No

HOW DID YOU HEAR ABOUT US? (Please be very specific, Who, Where)

Friend: _____ Family: _____ Workplace: _____ Referring Physician: _____

PLEASE CIRCLE ALL THAT APPLY WHERE YOU MAY HAVE SEEN OR HEARD OUR ADVERTISING

Indianapolis Woman/Indianapolis Mthly	Magazine/New Beauty	Radio/Television (which station)
Physician	Revelation Fitness	RSVP/Coupon
Yellow Pages	Seminar-: _____	Drive By
Jr. League of Indianapolis	Billboard	Newspaper/Daily Journal
ASPS	Email Newsletter	Indianapolis Star
Internet/Website (Please be specific, Search engine, what you typed to get to location): _____		Other: _____

General Consent for Medical Services

I certify that the information above is correct to the best of my knowledge. I authorize Dr. Kimberly Short and employees of the Gillian Institute to furnish medical care and in-office surgical procedures that are necessary for medical treatment. I acknowledge that no guarantees as to results have been made to me.

Consent to Take Photos

I hereby authorize Dr. Kimberly Short and/or qualified staff to take photos necessary for cosmetic surgery I may have performed and permit the use of these photos for medical records.

Date: _____ Patient/Legal Guardian Signature: _____

Date: _____ Witness Signature: _____