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**LAM FACIAL PLASTICS Today’s Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Samuel M. Lam, M.D., F.A.C.S.

All cosmetic consultations incur a consultation fee of $150.00, applicable to any treatment for 90 days post consultation.

Name: First \_\_\_\_\_\_\_\_\_\_\_\_\_ (Preferred \_\_\_\_\_\_\_\_\_\_\_) M.I. \_\_\_ Last \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ D.O. B. \_\_\_\_/\_\_\_\_/\_\_\_\_\_

Street Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Apt. # \_\_\_\_\_\_\_\_

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_\_\_\_\_\_\_Zip \_\_\_\_\_\_\_\_\_\_\_\_\_

Sex \_\_\_\_\_ M \_\_\_\_\_ F SS#: \_\_\_\_-\_\_\_-\_\_\_\_\_ Employer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Occupation\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What is your preferred method of contacting you?

Home Phone (\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_ Work (\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_Cell (\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_E-Mail \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

May we text you regarding upcoming appointment information? \_\_\_\_ YES \_\_\_\_\_ NO

May we leave a voice mail message? \_\_\_ YES \_\_\_ NO

May we mail you information on events or new procedures? \_\_\_ Yes \_\_\_ NO

Under HIPAA regulations we cannot disclose your health information to anyone else without your consent.

Please list person(s) that you authorize to discuss your health information with:

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Would this also be your emergency contact? If not, who would that be?

Emergency Contact \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary Physician \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Pharmacy Phone# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How did you hear about us? (Who referred you?) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What is your primary interest in coming here? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**For Hair Transplant Candidates**:

What is your primary interest in coming here? Hair Loss ­­­\_\_\_\_ Hair Restoration \_\_\_\_\_

How long have you been concerned about your hair loss? Less than one year \_\_1-5 years \_\_ greater than 5 years \_\_\_

**Have you tried any of these hair solutions:** Propecia \_\_\_ Rogaine \_\_\_\_ Hair transplant \_\_\_\_\_ Hairpiece \_\_\_ Laser \_\_\_

By signing below, I understand & agree to all stated & filled in above. I also understand my rights are protected by the Privacy Act HIPAA and that I may request a copy of this at any time.

Name (print) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_

# All fees are due the day of treatment – Thank you!

Federal Law requires us to obtain a valid Driver License or current Photo ID for your records.

Thank you for entrusting us with your care!