

Dr ELIZABETH MCCORKLE

PATIENT INTAKE FORM

Name _____ Date of Birth ___/___/___ Age _____

Address _____

Preferred Phone _____ Email _____

Who referred you _____

In case of emergency, who should be notified? _____ Phone _____

Primary Care Physician _____

What medical problems do you have?

What surgeries have you had?

What medications do you take - please include herbals and over the counter products?

What allergies do you have, please include medication allergies?

Y N Do you have a history of cold sores?

Y N Do you have abnormal bleeding or bruising?

Y N Have you had BOTOX injections before?

Y N Have you ever used Fillers before?

Y N If you have used BOTOX or Fillers before, did you experience a problem?

Y N To the best of your knowledge, are you pregnant or nursing?

Y N I understand that should I become pregnant or am nursing, it is my responsibility to notify Dr Elizabeth McCorkle prior to my appointment to prevent a possible serious health risk

May Dr Elizabeth McCorkle's office have your permission to:

Y N Leave a message on your voicemail?

Y N Send you a text message reminder?

Y N Send you an email regarding promotions or specials?

DR ELIZABETH MCCORKLE has a 24 hour cancellation policy.

____ I am a responsible and thoughtful adult who does not cancel appointments with less than a 24 hour notice unless there is a true emergency.

____ I understand that if I do cancel my appointment with less than 24 hours notice I will be charged \$50

____ I understand that in order to provide the best experience for all clients I need to arrive at my scheduled appointment time and that my late arrival may require my appointment to be rescheduled

Signature _____ Date _____