

# Welcome To Our Office!

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Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_  
What name do you prefer to be called? \_\_\_\_\_  
Home Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Telephone: ( ) \_\_\_\_\_ May We Leave A Message? YES NO  
Cell Phone: ( ) \_\_\_\_\_ May We Leave A Message? YES NO  
Work Phone: ( ) \_\_\_\_\_ May We Contact You At Work? YES NO  
Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_\_  
Email Address: \_\_\_\_\_ May We Send Information Here? YES NO  
Occupation: \_\_\_\_\_ SSN: \_\_\_\_\_  
Employer: \_\_\_\_\_  
Employer's Address: \_\_\_\_\_  
Who Referred You? \_\_\_\_\_ Family Physician: \_\_\_\_\_  
Your physician will be notified of your visit and result(s) unless otherwise stated NO  
Cardiologist (if applicable): \_\_\_\_\_

Responsible Party Or Next Of Kin: \_\_\_\_\_  
Relationship To Patient: \_\_\_\_\_  
Home Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Telephone: ( ) \_\_\_\_\_ Cell Phone: ( ) \_\_\_\_\_  
Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_\_  
Occupation: \_\_\_\_\_ SSN: \_\_\_\_\_  
Employer: \_\_\_\_\_  
Employer's Address: \_\_\_\_\_  
Work Phone: ( ) \_\_\_\_\_

How did you learn about our practice? (Please Circle)

- Internet – What Web Site? \_\_\_\_\_
- PlasticSugeryServices.Net Web Site? \_\_\_\_\_
- Hagerstown Magazine
- Friend – Who? \_\_\_\_\_
- Other Patient – Who? \_\_\_\_\_
- Phone Book: Hagerstown Martinsburg Gettysburg Frederick Allegheny  
Charlestown Jefferson County Chambersburg Waynesboro

I give permission for photographs to be taken before, during , and after my surgery for the purposes of documentation and educational purposes that may be in a photo book only provided my identity is not revealed by the pictures.

Sign \_\_\_\_\_





# Plastic Surgery Services

## Henry F. Garazo, MD, FACS

Person or persons to whom Plastic Surgery Services may disclose personal health information regarding treatment on your behalf. The order shall remain in the effect until revoked by me.

Name/Relation: \_\_\_\_\_ Telephone: (     ) \_\_\_\_\_

I acknowledge that I have received a copy of the Privacy Notice for Plastic Surgery Services.

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

# Henry F. Garazo, MD, FACS

## Plastic Surgery Services

**Cosmetic medical services or procedures of interest to you (please check all that apply)**

### Cosmetic Surgical Procedures

- Breast Augmentation (Enlargement)
- Mastopexy (Breast Lift)
- Breast Reduction
- Gynecomastia (Male Breasts)
- Liposuction
- Face Lift
- Blepharoplasty (Eyelids)
- Forehead Lift
- Nose Reshaping
- Lip Enhancement
- Otoplasty (Protruding Ears)
- Endoscopic Plastic Surgery  
-Minimally Invasive Surgery

### Cosmetic Non-Surgical Procedures

- Botox Injection For Wrinkles
- Prevelle Silk/Restylane/Fat Injections
- Laser Hair/Vein/Tattoo Removal
- Laser Skin Resurfacing  
-Cosmetic Wrinkle Treatment
- Microdermabrasion
- Skin Care Clinic  
-Featuring Bio Medic
- Medi-Spa Services At Sanctuary Spa

### How did you hear about us?

My physician, whose full name is \_\_\_\_\_

A friend or family member (name) \_\_\_\_\_

Another person not listed above \_\_\_\_\_

My insurance company provider directory \_\_\_\_\_

A seminar where I saw the doctor. The event was \_\_\_\_\_

An article or ad in \_\_\_\_\_

The yellow pages (which ad) \_\_\_\_\_

Internet (which site) \_\_\_\_\_

