BEVERLY HILLS PROFILES

9201 WEST SUNSET BOULEVARD SUITE M-130 WEST HOLLYWOOD,CA 90069

(310)276-6800 **www.beverlyhillsprofiles.com**

Patient Information

(Please Print Legibly & Fill In or Correct All Fields)

Patient's Name _____ Age Date of Birth _____

Last First

If Minor: Mother's Name_____ Father's Name_____

HomeAddress_____City_____Zip_____

Home Phone ( ) _____ Cell Phone ( ) _____ Preferred number: home work cell

Employer_____ Occupation_____

Business Address_____ Business Phone ( ) _____

D. L. State & #_____ SS#_____ E-Mail **_____

Ethnicity: _____ Sex:____ Marital Status: S M D W

Spouse's Name_____ Employer_____

EMERGENCY CONTACT NAME: _____ RELATIONSHIP :_____

Home Phone ( ) _____ Cell Phone ( ) _____

REFERRING PHYSICIAN:_____OFFICE PHONE#_____

Would you like us to contact your physician regarding your visit? _____

OTHER REFERRAL SOURCE:

INDIVIDUAL'S NAME AND RELATIONSHIP TO YOU: _____

MAY WE THANK THIS PERSON FOR REFERRING YOU? _____ Yes _____ No

Please fill out the below section:

These are areas of concern for me:	
❑ Acne	❑ Puffy eye area/dark circles
❑ Wrinkles and folds	❑ Ears
❑ Lines around mouth	❑ Nose
❑ Fine lines and wrinkles	❑ Neck
❑ Sun spots/Aged spots	❑ Short, thinning, or light eyelashes
❑ Sagging skin	❑ Chin
❑ Uneven skin tone	❑ Other

** We kindly request an email address where we can notify you when it's time for your next appointment. Due to medical privacy regulations, we will not share this with anyone.

CONSENT AND RELEASE FOR USE OF PHOTOGRAPHS, DIGITAL IMAGES, AND/OR VIDEOTAPE

I hereby authorize Dr. Solieman, Dr. Litner, aided by such assistants, photographers, or technicians as they may engage for this purpose, to take such photographs, digital recordings, and/or videos of me as he may desire at this time and before, during, and after any operation or procedure which is to be performed on me. I further grant these physicians the ongoing and unrestricted right to use the undersigned's images for general information, education, scientific, medical, and research purposes or for any other purpose which they may deem fit with the understanding that my name will never be used to identify myself. The images may be conveyed or displayed for those purposes through electromechanical means, including the Internet and Social Media- Facebook, Instagram, Twitter. I hereby give my Profiles Doctor the right and unrestricted permission to use, reproduce, or publish all such images, and I relinquish all right, title, and interest in these images to my Profiles Doctor. I may revoke this consent in writing, delivered to my Profiles Doctor. Such revocation shall therefore be effective as to any further use not already committed to by these physicians. This consent is in consideration of services performed and consultations conducted or to be performed or conducted by my Profiles Doctor. There have been no representations or inducements concerning this consent, except as set forth herein.

_____ DATE:_____

_____ DATE:_____
Witness

CONSENT BY PARENT OR GUARDIAN

I am the parent or guardian of a minor. I am authorized to sign this consent on his/her behalf, and I agree on my own behalf and his/her to the terms of the foregoing consent.

_____ DATE:_____
Parent/Guardian

_____ DATE:_____
Witness