THE NEW YORK AESTHETIC CONSULTANTS, LLP

260 East 66th Street New York, NY 10065 www.thenyac.com

Patient Name_____ **Patient Date of Birth**____/____/____

Please fill out the following as ***completely*** as possible. Please mark whether you would like a report sent to your doctor(s) regarding your visit or procedure.

Yes No **Dermatologist**_____ *phone #* (_____)_____

_____

address *city* *state* *zip code*

Yes No **Internist**_____ *phone #* (_____)_____

_____

address *city* *state* *zip code*

Yes No **Cardiologist**_____ *phone #* (____)_____

_____

address *city* *state* *zip code*

Yes No **Gynecologist**_____ *phone #* (____)_____

_____

address *city* *state* *zip code*

Yes No **Other**_____ *phone #* (____)_____

_____

address *city* *state* *zip code*

I authorize The New York Aesthetic Consultants, LLP to send a report concerning this and all future surgeries and/or consultations to the above doctors that I have marked.

The dermatologic examination that you are about to receive is neither a complete dermatologic nor complete physical examination. It is recommended that you have a complete physical examination periodically by your general physician. Any patient who has had a skin cancer should indefinitely follow up with a general dermatologist as there is a small chance of getting a new skin cancer at this site, regardless of treatment rendered. There is a considerable chance that there will be new skin cancer(s) arising in sun-exposed skin in the next several years.

I certify that all of the information I have provided on all questionnaires is correct and to the best of my knowledge. I will not hold Dr. Shelton, or any members of The New York Aesthetic Consultants, LLP responsible for any errors or omissions that I may have made in the completion of this form.

Patient Signature_____ **Date**____/____/____