Dr.
LOMBARDI'S
AESTHETIC LOUNGE

Anthony S. Lombardi MD, F.A.C.S.
Nilla Defazio, PA-C

Kimberly Raymond, MD
Kimberly Clemente, RN, APN

_____
Date

_____ **Patient's Last Name**	_____ **Patient's First Name**	_____ **M.I.**
_____ **Street Address**	_____ **City**	_____ **Zip Code**
_____ **Cell Phone**	_____ **Home Phone**	**M/ D / S / W**
_____/_____/_____ **Date of Birth (MM/DD/YY)**	_____ **Age**	**SEX:** M / F
_____-_____-_____ **Social Security Number**	_____ **Employer**	_____ **Occupation**
_____ **Emergency Contact**	_____ **Relationship**	_____ **Emergency Contact #**
_____ **Email Address**	_____ **How did you hear about us?**	

Allergies: _____

Medical History: _____

Current Medications: _____

Can we **CALL** / **TEXT** you to confirm appointments? **Y** / **N** Can we leave a **VOICEMAIL**? **Y** / **N**

Are you interested in receiving information via email? **Y** / **N**

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Patient Photo Consent

Please be aware that we will need to take before and after photos of your procedure.

We would like your permission for advertising purposes. For example, our company website, portfolios, online sites such as Facebook and Instagram as well as print ads.

Upon your approval, we will attach your photo to your personal file. Please indicate if you agree to your photo being used in company advertising.

◯ **Yes**, feel free to use my photos.

◯ **No**, do not use my photo for any advertising.

Signature:

Date:

Email Address: