

# *Palm Desert Plastic Surgery*

"A SURGEON'S HAND WITH A WOMAN'S TOUCH"

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Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_ Age: \_\_\_\_\_

Social Security #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Email Address: \_\_\_\_\_

Phone #: \_\_\_\_\_ Which # may we leave a detailed  
Home: \_\_\_\_\_ ☐ H message on?

Cell: \_\_\_\_\_ ☐ C

Work: \_\_\_\_\_ ☐ W

Occupation: \_\_\_\_\_

Employer: \_\_\_\_\_

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Separated

Spouse or Parent Name: \_\_\_\_\_

Primary Physician: \_\_\_\_\_ Ph #: \_\_\_\_\_

Referred By: \_\_\_\_\_

How did you hear of Dr. Quardt? \_\_\_\_\_

Health issues and concerns you would like to discuss with Dr. Quardt today.

☐ Face

☐ Breast

☐ Body

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## *Patient Information*

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Procedures or Products of interest to you.

### Face

- ☐ Browlift
- ☐ Chemical Peel
- ☐ Ear Lobe Correction
- ☐ Ear Pin Back/  
Otoplasty
- ☐ Eyelid lift
- ☐ Eyelids/  
Blepharoplasty
- ☐ Face Implants
- ☐ Fat Transfers
- ☐ Lip Augmentation
- ☐ Liquid Facelift
- ☐ Mini Facelift
- ☐ Mole/Growth Removal
- ☐ Neck Lift
- ☐ Neck Liposculpture
- ☐ Nose Revisions/  
Rhinoplasty
- ☐ Scar Revisions
- ☐ Spider Veins
- ☐ Sun Damage/Screen

### Breast

- ☐ Asymmetry &  
Deformities
- ☐ Augmentation
- ☐ Complex Revisions
- ☐ Congenital Deformities
- ☐ Inverted Nipples
- ☐ Lift/Mastopexy
- ☐ Male Gynecomastia
- ☐ Nipple Revisions
- ☐ Reconstruction
- ☐ Reduction
- ☐ Removal and Replacement  
of Implant

### Body

- ☐ Arm short scar/  
Brachioplasty
- ☐ Arm-lift
- ☐ Brazilian Butt-Lift/  
Gluteoplasty
- ☐ Circumferential Body Lift

### Body Cont

- ☐ Labiaplasty
- ☐ Laser Liposuction
- ☐ Liposuction
- ☐ Lower Body Lift
- ☐ Mommy Makeover
- ☐ Mons Pubis Lift
- ☐ Thigh Lift
- ☐ Tummy Tuck/  
Abdominoplasty
- ☐ Umbilicoplasty
- ☐ Vaginal external  
rejuvenation
- ☐ Weight-loss  
contouring

### Non-Surgical

Injectables:

- ☐ Botox/Dysport
- ☐ Fillers

Products:

- ☐ Eye lashes-Latisse
- ☐ Skin care creams- Rx

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Insurance Information: *Not necessary information for cosmetic consults*

If you have your insurance care with you we will gladly make a copy. If not, please furnish the following information:

Insurance Co. \_\_\_\_\_

Address: \_\_\_\_\_

Insured Name: \_\_\_\_\_ ID# \_\_\_\_\_ Grp # \_\_\_\_\_

I hereby authorize the release to my Insurance carriers of any and all information necessary to process Insurance payments for medical services rendered to myself or my dependents. I authorize and request my Insurance Company to pay directly to the Doctor the amount due on my claim for services rendered to me or my dependent. I further agree that should the amount be insufficient to cover the entire medical and/or

surgical expense, I will be responsible for the payment of the difference; and if the nature of the disability be such that is not covered by the policy, I will be responsible to the Doctor for payment of the entire bill.

Insured Signature \_\_\_\_\_ Date \_\_\_\_\_