SHAPIRO GROUP MEDICAL

PERSONAL DATA

Today's Date: _____/_____/____

Last Name: _____ First: _____ MI: _____

Home Address: _____ Apt.: _____

City: _____ State: _____ Zip: _____

E-mail: _____

Phone: _____

Occupation: _____

Gender: Male or Female **Date of Birth: ____/____/____ Current Age: _____**

You may contact me at: (Pease Circle) **Home Work Both Neither**

How did you hear about us? (Please Circle)

Physician Family Friend Patient Magazine

Yellow Pages Web Site Other _____

NAME OF PERSON TO THANK FOR REFERAL: _____

Making a choice to do something about your hair loss is a very important decision. It is important to feel comfortable and well educated about your options. The following information will help us in this process.

How much knowledge do you feel you have about the options available to treat hair loss:

(Please Circle) Very Little Moderate Extensive

Have you consulted other clinics: (Please Circle) Yes or No

What forms(s) of treatment are you most interested in at this time:

(Please Circle) Surgical Non-Surgical Medical Non-Surgical Cosmetic

Which of the following would you find most helpful:

(Please Circle) In Depth Consultation Talking to/Meeting Former Patients Observing Surgery