

ROBERT J. SPIES, M.D., P.C.
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PRE-CONSULTATION FORM

(Please complete all items. Please print neatly)

Name: _____ Date: _____

Name of your Family Physician or
Internist: _____

May we send a copy of our medical report to your physician? Yes
No

Referred by:

- Please My Doctor Name: _____)
Check Another Plastic Surgeon (Name: _____)
One Telephone Yellow Page Listing
 Another Patient (Name: _____)
 Maricopa County Medical Society
 American Society of Plastic and Reconstructive Surgeons
 Newspaper or Magazine Article
 Maricopa County Plastic Surgeons Society
 Radio or Television Program
 Other (Specify: _____)

Have you (or any member of your family) ever been treated by Dr. Spies for any condition before this visit ?

No If Yes, please explain _____

Briefly state why you are seeking a Plastic Surgery consultation: _____

Please state why you would like to have your particular disorder
corrected: _____

Do you have any specific concerns about any contemplated operation? _____

Have you talked with any other Doctors about this surgery? No Yes

Their names: _____

Have you ever been treated by a Plastic Surgeon for any condition? No Yes

If so, when? _____ Name of Surgeon: _____

Treated for what? _____