DAViD C. MABRiE, M.D.
Board-Certified Facial Cosmetic Surgeon

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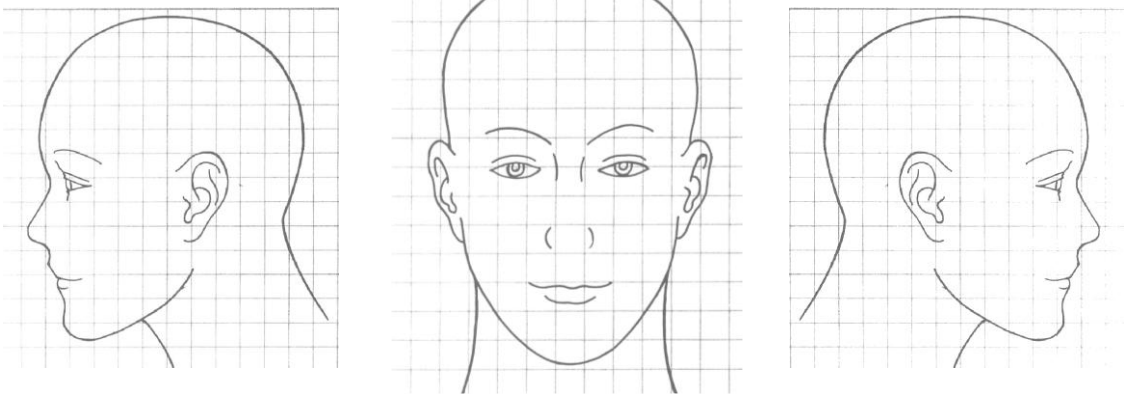
Name:_____ Date:_____

Draw on the images below to indicate your area of concern or surgical goal.



Indicate area/characteristic of concern or cosmetic goals:

☐ Wrinkles ☐ Coloration ☐ Fat ☐ Too Prominent ☐ Not prominent enough
☐ Would like to look more youthful ☐ Not sure; would like professional opinion

My Top 3 Questions

We strive to provide you with everything you need to make an informed decision about cosmetic surgery. You are unique and we will make every effort to meet your needs today. Please tell us the top 3 things on your mind you would like Dr. Mabrie to answer in the space below:

1. _____
2. _____
3.

Have you had previous treatments? (Botox, Fillers, Laser) ☐ No ☐ Yes

If Yes, how recent and were you happy with the results?_____

Any previous cosmetic surgeries? ☐ No ☐ Yes

If Yes, what procedure and when?_____

Any previous cosmetic consultations? ☐ No ☐ Yes

Time frame for surgery:_____As soon as possible _____1-3 months from now
_____Other _____Just need information

Is there an upcoming occasion or date you are working with? ☐ No ☐ Yes,_____
Is there a specific budget you would like us to meet? ☐ No ☐ Yes, $_____
Would you like to discuss financing options? ☐ No ☐ Yes