

**LVRI of Scottsdale**

8752 east Via De Commercio, ste #2  
Scottsdale, AZ 85258

**PATIENT NAME** \_\_\_\_\_  
LAST FIRST MIDDLE INITIAL

**HOME ADDRESS** \_\_\_\_\_  
STREET APT# CITY STATE ZIP

**BIRTH DATE** \_\_\_\_/\_\_\_\_/\_\_\_\_ **SS #** \_\_\_\_\_-\_\_\_\_\_-\_\_\_\_\_

**E-MAIL** \_\_\_\_\_ **PREFERRED CONTACT (CIRCLE):** HOME WORK MOBILE

**HOME TEL:** \_\_\_\_\_ **MOBILE:** \_\_\_\_\_ **WORK:** \_\_\_\_\_

**EMPLOYER** \_\_\_\_\_ **OCCUPATION** \_\_\_\_\_

**EMPLOYER ADDRESS** \_\_\_\_\_ **TEL** \_\_\_\_\_

**SPOUSE NAME** \_\_\_\_\_ **TEL** \_\_\_\_\_

**EMPLOYER** \_\_\_\_\_ **OCCUPATION** \_\_\_\_\_ **(W) TEL** \_\_\_\_\_

**EMERGENCY CONTACT** \_\_\_\_\_ **TEL** \_\_\_\_\_

**WHAT PROCEDURE ARE YOU INTERESTED IN?**

- |  |  |
|--|--|
| <input type="checkbox"/> Laser Vaginal Rejuvenation (tightening) | <input type="checkbox"/> Laser Reduction Labiaplasty |
| <input type="checkbox"/> Laser Perineoplasty                     | <input type="checkbox"/> Hymenoplasty                |

**HOW DID YOU HEAR ABOUT US?**

- |  |  |
|--|--|
| <input type="checkbox"/> Internet          | Google/MSN/Yahoo/Other _____                     |
| <input type="checkbox"/> Print Advertising | Phoenix Mag/944 Mag/AZ Foothills/Other _____     |
| <input type="checkbox"/> Friend/Family     | Who may we thank? _____                          |
| <input type="checkbox"/> Physician         | Who may we thank? _____                          |
| <input type="checkbox"/> Media/TV          | Dr. 90210/Fox 10/Other _____                     |
| <input type="checkbox"/> In-Office         | Current patient/Staff Member/Healthcare Provider |

**RELEASE OF INFORMATION: I authorize the release of any medical or other information necessary for my care. I authorize this office to discuss my care, treatment or billing information with the following person(s):** \_\_\_\_\_

**I understand any procedure performed by LVRI of Scottsdale is not covered by insurance; therefore, payment in full is required prior to any surgery/procedure.**

**PATIENT'S SIGNATURE** \_\_\_\_\_ **DATE** \_\_\_\_\_