WOLF
HAIR RESTORATION

Dr. Scott Welden

PATIENT REGISTRATION FORM

Name_____ Birthday_____/_____/_____ Age _____ Date _____

Sex: ☐ F ☐ M Phone# ( ) _____ Marital Status: ☐ Single ☐ Married Height _____ Weight_____

Address_____

City_____ State_____ Zip_____

Email _____

Employer/Occupation_____

How did you hear about us? ☐ Referral ☐ Instagram ☐ Facebook ☐ Website ☐_____

What are your hair loss and aesthetic goals?

_____

What services are you interested in?

☐ Hair Transplant ☐ Medical Hair Loss Treatment ☐ Platelet Rich Plasma (PRP)/Exosomes/Stem Cell Treatments

What hair loss medications, supplements, or topical treatments are you currently using?

AM:_____

PM:_____

Medical History _____

Current Medications (include aspirin and ibuprofen) _____

_____

Surgical History:_____

Allergies_____ Latex Allergy ☐ Yes ☐ No

Prior Hair Loss Treatments (please include date):

_____

Do you smoke? _____ Do you drink alcohol?_____ if yes, how many drinks/week?_____

Primary Pharmacy & Number: _____

SCHEDULING AND CANCELLATION POLICY

We require a $1,000 deposit to schedule and hold your surgery date. This deposit goes toward the cost of your procedure provided the following:

1. Cancellations made two weeks or more in advance of the surgery date are fully refundable.
2. Cancellations made 1-2 weeks prior to the date of scheduled surgery result in a 50% refund of the deposit
3. Cancellations or reschedules made less than 1 week prior to the surgery date result in a forfeited deposit. This fee is nonrefundable and cannot be used toward the cost of a futured scheduled procedure.

I have read and understand the above:

_____ _____

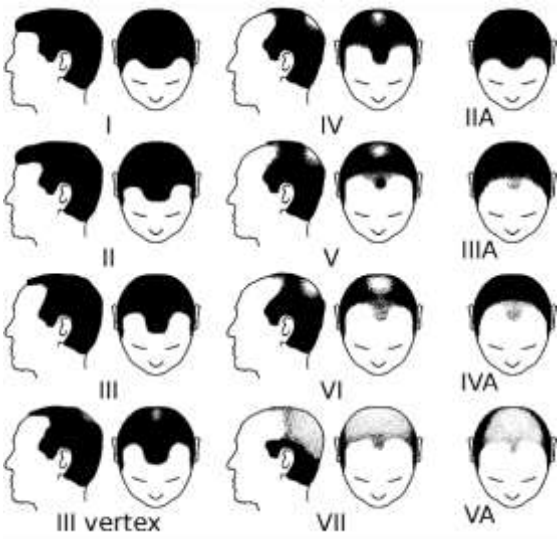
Patient's Signature Date

For office use only

Chief Concern:_____

History: _____

_____



PE:

S

Norwood:

☐Type I ☐Type II ☐Type III ☐Type IV ☐Type V ☐Type VI ☐Type VII

Evidence of Scarring Alopecia?_____

Notes: _____

_____

_____

_____

_____

_____

Estimate # Grafts Required:_____

Recommendations: Quote:

1. _____ $_____/graft
2. _____ $_____

Pictures taken: ☐ Yes ☐ No

Plan:

_____

_____

☐ All risks, benefits, and alternatives of the proposed treatment plan were discussed with the patient

_____ _____

Physician Signature Date