Blue Ridge Dermatology Associates, PA

SculpSure®

Treatment Consultation Form

Patient Name: _____ Date of Birth:_____ Date: _____

Gender: _____ Weight: _____ Height:_____ Age: _____ BMI:_____

Email: _____ Phone: _____

I authorize use of this email address to receive before/after pictures _____
(Patient Signature)

What are your areas of concern?_____

_____

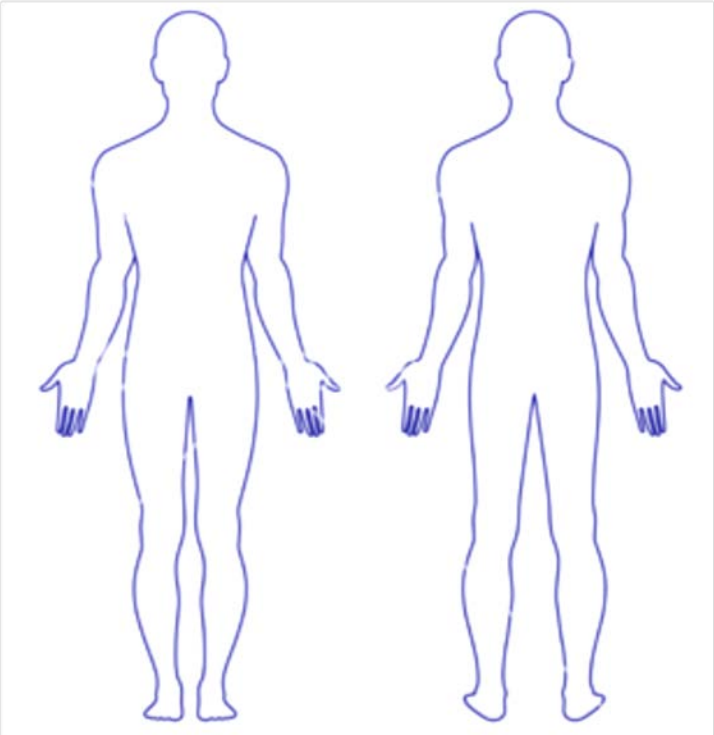
How did you hear about SculpSure®?_____

_____

Have you tried other fat loss methods? If yes, please list:

_____

For Office Use Only:



Front Back

Treatment Plan:

Abdomen

Frame Type(s): _____

# of Treatments: _____

Flanks

Frame Type(s): _____

# of Treatments: _____

Other _____

Frame Type(s): _____

# of Treatments:_____

Total # Applicators: _____

Pricing:

Treatment price: _____

Discount (if applicable): _____

Total: _____

Notes:_____

_____

_____