Tampa Bay Hair Restoration
Markou Medical
1266 Turner St. Clearwater, FL 33756
727.446.0608

Patient Information

Last Name: ______________________ First: ______________________ Middle: ______________

DOB: ______________ Age ________ Male _____ Female: ____ Married: ____ Single: _____ Divorced: _____

Address ____ City ______________ State __________ Zip ________

Cell Phone: ______________________________ Home Phone ______________________________

EMAIL: ____

Best Way To Be Contacted: Phone: ____ Text: _____ Email ______

Occupation: ____________________ Employer: ____________________ Work Phone: _________________

Emergency Contact: ____________________________ Contact Phone Number: _______________________

General Permission to Treat

The undersigned here by gives permission for Dr. Markou, D.O. and Any Licensed Staff Member to diagnose and treat their medical problems.

Patient's Signature: ____ Date: ______________________

List Any Drug Allergies: ____

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Current Medications: ____

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In order to properly thank your friends and acquaintances, please check all that apply:

Friend or Relative [ ] Instagram [ ] Facebook [ ] Google/Yelp Search [ ] Hair Stylist Barber [ ]

TV or Radio Ad [ ] Dr. ____________________ Other ______________________

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Family History: Please check any that apply to immediate family.

Heart Disease	High Blood Pressure	Stroke	Cancer	Glaucoma	Diabetes
Epilepsy/Convulsions	Bleeding Disorder	Kidney Disease	Thyroid Disease	Mental Illness	Osteoporosis

Patient Medical History: Please check any that apply to immediate family.

Anemia	Asthma	Bleeding Disorder	Cancer	Depression
Diabetes	GI Disorder	Hepatitis	Heart Palpitations	High Blood Pressure
HIV Infection	Mental Illness	Prostate Cancer	Sexual/Menstrual Dysfunction	Thyroid Disease

Other: ______________________________

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Hospitalization or Surgery: ______________________________

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Habits: Check any that apply.

Alcohol	Caffeine	Exercise	Marijuana	Smoke

Date of your last physical and/or labs: ______________________________

Have you had any local anesthesia issues? (Difficult to numb at dentist office): Yes [ ] No [ ]

If yes, please explain: ______________________________

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Have you been to another Hair Transplant Consultation prior to visiting Dr. Markou? Yes [ ] No [ ]

If yes, what options have you discussed? ______________________________

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Have you had a previous Hair Restoration Procedure(s)? Yes [ ] No [ ]

If yes, please list the Doctor's Name, Clinic and Date of Procedure: ______________________________

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Please check any treatments that you had prior or currently utilizing:

Platelet Rich Plasma, PRP	Propecia (Finasteride)	Rogaine (Minoxidil) 2% [ ] or 5% [ ]
Low Level Laser Treatment	Other Non-Surgical Treatments	

How soon are you considering to have your procedure? 1 Week [ ] 1 Month or More [ ] Not Sure [ ]

Are you considering FUE (ARTAS) OR FUT (STRIP)? FUE (ARTAS) [ ] FUT (STRIP) [ ]

What area(s) are you interested in restoring? Frontal [ ] Mid [ ] Crown/Vertex [ ]

Do you form large scars when healing, keloids? Yes [ ] No [ ]

The above information is true to the best of my knowledge. I understand that I am financially responsible for any balance. I also authorize Tampa Bay Hair Restoration-Markou Medical to release any information required to process my claims.

Patient Signature: ______________________________ Date: ______________

Tampa Bay Hair Restoration – Markou Medical

Receipt of Notice of Privacy Practice Written Acknowledgement Form

I, ______________________________ have received a copy of Tampa Bay Hair Restoration – Markou Medical notice of privacy practices.

Patient Signature: ______________________________ Date: ______________