SculpSure®

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Treatment Consultation Form

Patient Name: ____

Date: _____/________/________

Address: ____

City/State: ____________________________________ Zip Cpde: ______________

Gender: _________ Weight: __________ Age: _____

Phone: ____________________________

Email: _______________________________________

What are your areas of concern? ____

How did you hear about SculpSure and our practice? ____________________________
____

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

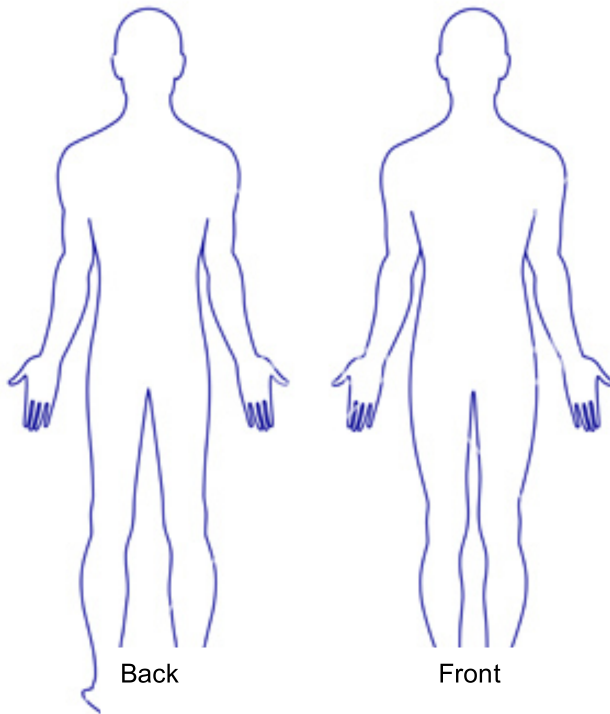
What was your experience? ____

Are you preparing for a special events? ____

If yes, when is the event? ____

Any other comments or concerns you would like the doctor to know? ______________
____

For Office Use ONLY:



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: ____________________________

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