

Plastic Surgery Practice Marketing: Surgeon Application

Please fax this application back to 815-550-1086 or scan and email back to applications@pspm1.com

PRACTICE INFORMATION

Doctor: _____ Name of Practice: _____

Address of Practice: _____

Telephone Number: (____)____-____ Fax Number: (____)____-____ Back Line Number: (____)____-____

Office Manager: _____

	Last Name	First Name	Extension	Email
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Receptionist: _____

	Last Name	First Name	Extension	Email
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Patient Coordinator: _____

	Last Name	First Name	Extension	Email
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Patient Leads Email Address: _____

Website: _____ Dr. Email address: _____

SURGICAL SUITE

Certification: _____ No. of Suites: _____ No. of Consult Rooms: _____

LV. Sedation: _____ Gen. Anesthesia: _____ Laser(s): _____

Main Technique for performing a Breast Augmentation: _____

List any additional methods that you perform: (i.e., Areola, Armpit, Sub-fascial or through the navel)

What method do you use for Liposuction: (i.e., Tumescent, Ultrasonic, Power Assisted, SmartLipo, Cool lipo, etc.) _____

1. ARE YOU ABLE TO PERFORM BREAST AUGMENTATION?

a. TRANS-AXILLARY: YES NO

b. AREOLA: YES NO

c. INFRAMAMMARY: YES NO

d. TRANSUMBILICAL: YES NO

e. UNDER THE MUSCLE: YES NO

f. ABOVE THE MUSCLE: YES NO

g. PERFERRED METHOD: _____

WHAT IMPLANTS DO YOU OFFER IN YOUR PRACTICE?

a. SMOOTH ROUND SALINE: YES NO

b. HIGH PROFILE: YES NO

c. SILICONE GEL: YES NO

3. WHAT METHODS OF LIPOSUCTION DO YOU PERFORM?

a. TUMESCENT: YES NO

b. ULTRASONIC: YES NO

c. POWER ASSISTED: YES NO

d. VASER LIPO: YES NO

4. DO YOU OFFER LASER LIPO? YES NO

5. DO YOU USE COMPUTER IMAGING? YES NO

6. DO YOU OFFER THE FOLLOWING BUTTOCK PROCEDURES?

a. BUTTOCK IMPLANTS? YES NO

b. FAT TRANSFER/INJECTION TO THE BUTTOCK? YES NO

c. BUTTOCK LIFT? YES NO

Experience & Procedures

Since board certification, how many years experience do you have? _____

Please fill in the approximate number of these procedures you have done over the last 2 years

Last 2 Years

- Full Face Lifts w Smas _____
- Face Lifts skin only _____
- Lower Eyelids _____
- Upper Eyelids _____
- Endoscopic Open Coronal _____
- Gynecomastia _____
- Neck Plications _____
- Otoplasties _____
- Rhinoplasties _____
- Fat Transfer to Cheeks _____
- Fat Transfer to Lips _____
- Lip Augmentations _____
- Chin Implants _____
- Cheek Implants _____
- VY Plasty Lips _____
- Brow Lifts _____
- Abdominoplasties _____
- Brachioplasties _____
- Breast Augs _____
- Mastopexies _____

Signature of Office Manager

BOARD CERTIFICATION

Date: _____

Dr. _____, is a surgeon certified by the American Board of Medical Specialties and licensed to practice medicine in the state of _____. His/her board certification(s) is(are) _____

I further understand that PSPM and its officers, agents, and employees will be discussing his/her board certification(s) with potential patients based on my representations. I hereby attest that the above statements are true and correct to the best of my knowledge.

Certified By: Name: _____

Title _____

Signature _____