

CONSULTATION FORM

PATIENT INFORMATION	
Name	
Date of Birth	
Branch of Military Active / Non Active? Must attach proof of service.	
Address, City, State, Zip	
Phone Number	
Email	
How old is the scar(s)?	
Have you had prior surgery or treatments to fix your scar(s)? Explain if Yes.	
On a scale of 1-10, 10 being the highest, how does your scar affect your everyday? Explain.	
What realistic improvement(s) would you like for your scar?	
Is there a specific part of your scar that bothers you the most? Explain.	
How did you hear about us?	
Which location is best for you, Tampa or Coral Gables, FL?	

Please attach clear photos of your scars (front and side view) and send with this form to Info@vetsscarfoundation.com.