Name_____
Date_____
Phone #_____

Please turn in this form to the reception desk once it is completed.

Bluemound Medical Center Questionaire

1. Do you have any desire/interest for dental care for pain, Cosmetics, regular cleanings, Orthodontics, Whitening or other dental services?

   Yes □ No □ Maybe □

2. Do you have any desire/interest for Plastic Surgery, Skin Rejuvenation or Spa Treatments?

   Yes □ No □ Maybe □

3. Do you have any desire/interest for weight loss, nutritional planning, or Bariatric Surgery?

   Yes □ No □ Maybe □

4. Do you have any desire/interest for Exercise Rehabilitation, therapeutic massage, or Chiropractic services?

   Yes □ No □ Maybe □

5. Do you have any desire/interest in treating leg pain, or varicose veins?

   Yes □ No □ Maybe □

6. Do you have any desire/interest in Orthopedic Surgery services?

   Yes □ No □ Maybe □

7. Do you have any desire/interest in Hearing aids or ear services?

   Yes □ No □ Maybe □

8. Do you have any desire/interest in any Dermatology Services?

   Yes □ No □ Maybe □

I consent to having the above information sent to one of the offices in the Bluemound Medical Center to contact me for further information.

Signature_____