PATIENT INFORMATION

PLEASE FILL OUT COMPLETELY AND SIGN WHERE INDICATED
(PLEASE PRINT)

LAST NAME ________________ FIRST NAME ________________ MI ____ TODAY'S DATE ________

MAILING ADDRESS ________________ CITY ________ STATE ____ ZIP ______

Sex: (Circle one) Male Female Date of Birth: _____/_____/_____ Age:__________

(1) Home Phone: ( ) _____-___________ (2) Work Phone: ( ) _____-____________

(3) Cell Phone: ( ) _____-___________ Please indicate which number your prefer as our contact #

Employer: ______________________________ Occupation:________________________

EMERGENCY CONTACT

Emergency contact: Name of nearest relative or friend **NOT** living with you, to contact in case of an emergency.

Name: ________________________ Home Phone: ________________ Other: ____________

Relationship: ___________________ City: ___________________ State: ______________

REFERRAL SOURCE

How did you hear about our office? ____

If friend/patient please list their name: ____

May we send them a thank you note and reference your name? Yes No

Throughout the year, we would like to send you the latest updates on cosmetic surgery, skin care and any special offers and savings that may interest you. If you would like to receive these emails, please sign below and provide your email address. We respect your privacy. Your email will never be shared or sold. At any time, you can call or email us to be removed from the list.

Signature ______________________________ Email Address ______________________________

OFFICE POLICIES

- Payment for service is due when rendered
- We accept cash, check, Visa, Mastercard, American Express, and Discover as methods of payment.
- We require a 24-hour notice of cancellation for appointments.
- There is a $50.00 'no show' fee!