How did you hear about our office? (Please circle) **Yellow Pages Internet TV Mailer Doctor Friend**

Who may we thank for your referral? _____

Reason for visit: _____

_____

Would you be interested in financing any of your cosmetic procedure(s)? **Y** or **N**

Patient Name: **First** _____**M.I.** ____**Last** _____

Address _____City _____State ____Zip Code _____

Telephone: **Hm** _____**Wk** _____ **Cell** _____ *May we contact you by text message?* **Y** or **N**

E-mail: _____*May we contact you by e-mail?* **Y** or **N**

Birth date _____/_____/_____ Age _____ Social Security Number _____-_____-_____

Employer Name_____ Occupation _____

Insurance Provider_____ Name of Insured _____

DOB of Primary Insured _____/_____/_____ Name of Spouse/ Parent _____

Emergency Contact _____ Relationship _____

Telephone: **Hm** _____ **Cell** _____

I understand that I am responsible for the payment of all services rendered. The above information provided is true to the best of my knowledge.

I authorize the release of information regarding my treatment to my insurance carriers and billing company. I also authorize payment of medical benefits to the provider of services rendered. I understand that I am responsible for any amount not covered by my insurance.

SIGNATURE_____ DATE_____