

CENTER FOR COSMETIC SURGERY

ADULT

Over 18; not a full time student.

PATIENT INFORMATION

Date: _____

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

Last Name _____ First Name _____ Middle Initial _____ Nickname _____

Mailing Address _____ City _____ State _____ Zip _____

Sex: (circle one) Male Female Date of Birth: ____/____/____ Age: _____ Home Phone: _____

Soc. Sec. No.: _____ - _____ - _____ Email: _____ Is the Patient currently employed? (circle one) Yes No

Employer: _____ Occupation: _____

Work Phone: (____) _____ - _____ Ext. _____ Cell: (____) _____ - _____

Is the Patient? (circle one) Single Married Separated Divorced Widowed

Primary Care Physician _____ Phone Number _____

If you circled Married, please complete Spouse Information below.

Spouse's Last Name _____ First Name _____ Middle Initial _____ Nickname _____

EMERGENCY CONTACT

Emergency contact, give the name of nearest relative or of a close friend not living with you, to contact in case of an emergency.

Name: _____ Home Phone: _____ Work Phone: _____

Relationship: _____ City: _____ State: _____

INSURANCE INFORMATION - IF APPLICABLE

In order to avoid error or delay in the processing of your insurance claim, it is essential that the following section be completely filled out.

PATIENT'S HEALTH INSURANCE

Insurance Company: _____

Ins. Co. Address: _____

City: _____ State: _____ Zip: _____

Area Code: _____ Phone: _____

Policy Holder: _____

Social Security Number: _____

Employer: _____

Group No.: _____ ID No.: _____

**PLEASE SIGN
BY BOTH X'S**

I authorize payment of medical benefits to undersigned physician or supplier for these services and all future claims.

X _____
Signed (Insured or Authorized Person)

I authorize the release of any medical information necessary to process this claim and all future claims.

X _____
Signed (Insured or Authorized Person)

Special offers and cosmetic newsletters via email!

Throughout the year, we would like to send you the latest updates on cosmetic surgery, skin care, and laser treatments via our email newsletter. We will also periodically send special offers and savings that may interest you. If you would like to receive these emails, please sign this form and include your email address. Thank you.

Name: _____

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.

**How did you hear
about our office?** _____