NEW PATIENT FORM

REJUUUUVE 4 YOU

REFERRED BY _____

LAST NAME _____ FIRST NAME _____

HOME PHONE _____ CELL PHONE _____

EMAIL _____

*PROVIDING THIS INFORMATION GIVES US PERMISSION TO CONTACT YOU. YOU ARE SIGNING UP FOR OUR MAILING LIST.

ADDRESS _____

CITY _____ STATE _____ ZIP CODE _____

MARITAL STATUS ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED

DATE OF BIRTH _____ AGE _____ SEX AT BIRTH _____

OCCUPATION _____ EMPLOYER _____ WORK PHONE _____

SPOUSES NAME/OCCUPATION _____

FAMILY PHYSICIAN _____ PHONE _____

WHAT PROCEDURE(S) ARE YOU INTERESTED IN? _____

HAVE YOU SEEN ANOTHER DOCTOR ABOUT THIS? _____

IF SO, WHAT HAPPENED WITH SAID DOCTOR? _____

WHEN ARE YOU THINKING ABOUT HAVING THIS PROCEDURE? ☐ ASAP ☐ 1-3 WEEKS ☐ 4-8 WEEKS ☐ 2-6 MONTHS ☐ 6-12 MONTHS ☐ 12+ MONTHS ☐ JUST HERE FOR A PRICE QUOTE

WHAT INFORMATION WILL MOST HELP YOU DECIDE ON THE PHYSICIAN, STAFF, AND FACILITY TO DO YOUR SURGERY?

☐ REPUTATION ☐ CONFIDENCE ☐ TRUST ☐ SAFETY ☐ QUALITY ☐ RESULTS ☐ PRICE

☐ CONVENIENCE ☐ EXPERINCE ☐ FACILITIES ☐ BOARD CERTIFICATION

PROPOSED METHOD OF PAYMENT ☐ CASH ☐ CHECK ☐ CARD ☐ LOAN/ FINANCING

EMERGENCY CONTACT

NAME _____ PHONE _____ EMAIL _____

RELATIONSHIP TO YOU _____

AS A REMINDER, **ALL PREVIOUS BALANCES ARE DUE AT TIME OF SERVICE - NO EXCEPTIONS**! THERE IS A CANCELLATION FEE OF $40 IF YOU DO NOT INFORM THE OFFICE OF YOUR CANCELLATION WITHIN 48 HOURS OF YOUR SCHEDULED APPOINTMENT. I ACKOWLEDGE THAT I AM RESPONSIBLE FOR ALL THE CHARGES AND SERVICES RENDERED TO ME

PATIENT SIGNATURE _____ DATE _____