

- Dr. Smith
- Dr. Greco
- Dr. Dascombe
- Dr. Paletta
- Dr. Most

The Georgia Institute For Plastic Surgery

- Single
- Married
- Widowed
- Divorced
- Separated

PATIENT INFORMATION SHEET

Have you ever been seen by one of our doctors? No Yes, in what year? _____

Patient Legal Name _____ Nickname _____
Last First Initial

Sex _____ Date of Birth _____ Age _____ Social Security # _____

Home Address _____
Street City State Zip

Home Phone# _____ Cell / Alternate Phone# _____

Employer _____ Work Phone # _____

Name of Closest Relative, Friend or Neighbor _____ Phone # _____

Patient Primary Care Physician _____ Phone # _____

Referred by Dr. _____ Phone Book Radio Postcard Web Other

Specific Reason for Visit _____

Required Information

Email Address _____ /May we contact you through email Yes No

Would you like to receive our quarterly newsletter through E-zine? Yes No

 Name of Responsible Party, if other than patient _____
Last First Initial

Home Address if different from above _____
Street City State Zip

Home Phone # _____ Cell/Alternate Phone# _____

Employer _____ Work Phone # _____

 I, _____, represent to the physicians and staff that I am at least 18 (eighteen) years of age or, if not, am accompanied by a legal guardian. I hereby consent to and authorize examination and the treatment by my doctor and such assistant or staff as may be assigned by him/her.

I authorize the release of any medical information for the purpose of processing insurance claims on my behalf. I authorize payments of any medical benefits directly to the doctor for services provided to me. A copy of this authorization shall be considered as valid as the original. In the event of any litigation arising from treatment. I agree to submit the case to arbitration. I understand that photography is a necessary part of planning and evaluating cosmetic or reconstructive surgery. I authorize the taking of photographs at the direction of my surgeon and under such conditions as may be approved by him/her. These photographs will be used solely for documentation purposes and will be kept confidential.

I understand that there may be a consultation fee for the initial visit which is due at the time of my appointment unless other arrangements have been made in advance.

SIGNATURE: _____ DATE: _____

RELATIONSHIP: (Circle one) P A T I E N T S P O U S E P A R E N T G U A R D I A N