DAVID STEPHENS MD

PLASTIC SURGERY | AESTHETICS

Date_____

PATIENT REGISTRATION FORM

Last Name	First Name	Middle Initial

Date of Birth	Age	Social Security Number	If under 18 years of age, name of parent or guardian:

Home Address *(including PO Box)*	City	State	Zip Code

Home Phone Number	Mobile Phone Number

May our office leave you a **voice message** at all of the phone numbers you provided? Yes ☐ No ☐
May our office correspond with you via **text message**? Yes ☐ No ☐

Email Address

May our office correspond with you via **email**? Yes ☐ No ☐

Marital Status (*circle one*)

Single Married/Partner Separated/Divorced Widowed

Do you have children? Yes ☐ No ☐
If yes, please include ages:

Patient Employment Information

Employer Name	Occupation	Address

Spouse Employment Information (*if applicable*)

Spouse's Name	Employer Name	Occupation	Address

Person Responsible For Bill (*if not patient*)

Relationship To Patient (*circle one*) Spouse Parent Other

Name	Address	Phone Number

Insurance Information

Company	Subscriber's Name	Subscriber's Employer	Group Number	ID Number

Primary Care Physician

Name | Address | Phone Number

Emergency Contact Information

Name | Relationship | Primary Phone Number | Secondary Phone Number

Do you have a Living Will or Advanced Directive? Yes ☐ No ☐

How did you hear about us?

☐ Google ☐ Instagram ☐ 425 Magazine

☐ RealSelf ☐ Facebook ☐ Fundraising Event

☐ Yelp ☐ Real Patient Ratings ☐ Other _____

☐ Friend/Referral _____

May we thank your referral? Yes ☐ No ☐

Any special reason why you chose our office? _____

_____

E-Newsletter

Signup for our E-Newsletter? Yes ☐ No ☐

Receive exclusive offers, be the first to hear about specials, events and practice news.

I understand and hereby affirm that the information given above is accurate and complete to the best of my knowledge.

• I hereby authorize David Stephens, MD to release medical information accumulated in the course of my examination and/or treatment to any other doctor, hospital, nursing home or insurance company. I authorize the release of medical information contained in any doctor or hospital record to Dr. Stephens.

•I hereby agree to full-responsibility for all expenses incurred by or on the account of the above named patient.

Signature _____ Date _____

Signature _____ Relationship _____ Date _____

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