

The Museum Spa & Laser Center
A Part of Specialists in Plastic Surgery, P.A.

CHART #: _____

DATE: _____

NAME OF PATIENT:

LAST FIRST MIDDLE

ADDRESS: _____
STREET AND APT # CITY STATE ZIP CODE

AGE: _____ **DATE OF BIRTH:** ____/____/____ **GENDER:** _____ **HOME PHONE:** _____

WORK PHONE: _____

EMAIL: _____ **CELL PHONE:** _____

Preferred method(s) to contact you: Home Cell Work

May we leave a message? _____ **May we call you at Work?** _____

EMPLOYED BY: _____ **OCCUPATION:** _____

SPOUSE'S/SIGNIFICANT OTHER'S NAME: _____ **SPOUSE'S PHONE:** _____

REFERRED BY FRIEND – NAME: _____

REFERRED BY PHYSICIAN – NAME: _____

PRIMARY MEDICAL DOCTOR – NAME: _____

EMERGENCY CONTACT - NAME: _____

RELATIONSHIP: _____

WORK PHONE: _____ **HOME/CELL PHONE:** _____

RESPONSIBLE PARTY (Please complete only if patient is a minor.)

NAME: _____ **RELATIONSHIP TO PATIENT:** _____
LAST FIRST MIDDLE

ADDRESS: _____ **HOME PHONE:** _____
STREET AND APT # CITY STATE ZIP CODE

DATE OF BIRTH: ____/____/____ **EMPLOYED BY:** _____

I understand that I am financially responsible for all services, treatments & procedures & payment is due at the time services are rendered. I authorize all pertinent information to be released to my referring physicians, primary care physicians and my insurance carriers. I understand that the parent or guardian requesting treatment for a minor is responsible for all fees and services rendered.

Signature _____ **Date** _____

Patient or Responsible Party