HUNTINGTON WOMEN´S HEALTH

Aesthetics-Cosmetic Surgery-Gynecology

Why Wait Any Longer… Restore Your Youth Today!

Date_____

Patient's Last Name _____

First Name _____ **D.O.B** ____/____/____ **AGE** ____

Address_____City/State _____

Zip_____

Home Number (____) _____-_____Cell Number (____) _____- _____

Email:_____

IF PATIENT IS A MINOR, NAME OF PARENT_____

Pharmacy:_____ Pharmacy #: (___)_____-_____

Patient's employer's name _____Occupation _____

Work Number (____) _____- _____

Work Address_____

City/state _____ Zip _____

HOW DID YOU HEAR ABOUT US?
Friend: _____
Our Patient: _____
Magazine:_____
Internet: _____
Website: _____
Television:_____
Physician Referral: _____
Other (please specify): _____

PLEASE READ: ALL CHARGES ARE DUE AT THE TIME OF SERVICES. IF SURGERY IS INDICATED, THE PATIENT IS RESPONSIBLE FOR FURNISHING INSURANCE CLAIM FORMS TO THE OFFICE PRIOR TO SURGERY. ALL PROFESSIONAL SERVICES RENDERED ARE CHARGE TO PATIENT. NECESSARY FORMS WILL BE COMPLETED TO EXPEDITE INSURENCES CARRIER PAYMENT. THE PATIENT IS RESPONSIBLE FOR ALL FEES, REGARDLESS OF INSURENCES COVERAGE. IT IS CUSTOMARY TO PAY FOR SERVICES WHEN RENDERED UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE IN ADVANCES.

SIGNATURE: _____

- ☐ I consent to medical test and procedures in the office as may be deemed necessary for my care.
- ☐ I consent to receiving information from your practice via EMAIL ___ TEXT __ PHONE ___ MAIL ___.
- ☐ Please DO NOT contact me with any information about your practice. Follow my HIPPA release for health related correspondences.

Signature _____ **Date** _____

Parent/Guardian info (To be completed if the patient is a minor or if a guardian of attorney over the patient medical care)

Name (Last, First, Middle): _____
Home Phone: _____ Cell Phone: _____
Work Phone: _____
Email Address: _____