

HARTSDALE MEDSPA

WEIGHT LOSS & LASER BODY CONTOURING

PATIENT INFORMATION FORM

Patient Name (Last, First) _____

Address _____

City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____

Email _____

Date of birth _____ Age _____ Sex _____

Country of birth _____ Country of parent's birth _____

Social Security # _____ Drivers License State and # _____

Education (circle highest level achieved)

Elementary High School/Technical 2 yr College 4yr College Graduate School

Employment Information

Employer Name _____ Occupation _____

Employer Address _____

City _____ State _____ Zip _____

Work Phone _____ Ext. _____

Emergency Information

Name _____ Relation _____ Phone _____

Patient Spouse _____ Phone _____

Family Physician _____ Phone _____

Referred by _____

Financial Policy

This is to inform you of our billing requirements and financial policy. Please be advised that payment for all services will be due at the time services are rendered.

I agree that should my account be referred to an agency or an attorney for collection, I will be responsible for all collection costs, including but not limited to attorneys and court expenses.

I have read and understand all of the above and agree to these statements.

Patient's Signature _____ Date _____