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