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? ____________________

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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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