CHANGES

· PLASTIC SURGERY & SPA ·

Mr. / Mrs. / Ms. / Miss Nickname _____

NAME (last, first, MI):_____

Address:_____ Unit # _____ City & State:_____ Zip: _____

Home Phone #: (_____)_____ Work Phone #: (_____)_____ ext _____

Cell Phone #: (_____)_____ E-Mail _____

May we contact you: Y or N

Date of Birth:_____/_____/_____ Age: _____ Sex: Male / Female

PATIENT EMPLOYMENT INFORMATION:

Occupation:_____ Employer:_____

Address:_____ City:_____ State: _____

Phone #: (_____)_____

HOW DID YOU FIND US? Google/ RealSelf / Facebook / Yelp / San Diego Magazine / Other Internet _____
(please circle one) (source name)

REFERRED BY:_____ Phone#: (_____)_____

MARITAL STATUS : SINGLE MARRIED DIVORCED SEPARATED WIDOWED

SPOUSE:

Name:_____ Date of Birth:_____

Home Phone #: (_____)_____ Work #: (_____)_____Cell # (_____) _____

EMERGENCY INFORMATION (a relative or friend not living with you):

Name:_____

Relationship:_____

Address:_____ City & State:_____

Zip:_____

Phone#: (_____)_____ Cell Phone # (_____)_____

I hereby irrevocably assign and transfer all payment of benefits for the services rendered by Gilbert W. Lee, M.D. to be made directly to him regardless of my insurance benefits, if any, and agree to allow a photocopy of my signature to be used to file insurance. I understand that each patient (or responsible party) is financially responsible for services rendered. While the Business Office is pleased to assist in the preparation and submission of insurance forms, the obligation for payment remains that of the responsible party. In the case of an accepted Worker's Compensation injury, it is understood that the patient is not financially responsible. I also authorize Gilbert W. Lee, M.D. to render medical treatment.

_____ _____

PATIENT SIGNATURE **RESPONSIBLE PARTY SIGNATURE**

_____ _____

DATE **DATE**