Clinique Dallas
PLASTIC SURGERY
MEDSPA & LASER CENTER

PATIENT INFORMATION

Patient's Legal Name: ____________________ **Today's Date:** ____/____/_____
Last Name First Name Middle

Date of Birth: _____/______/______ **Age:** _________ **SSN:** _______-_______-_______ **Height:** ___'____" **Weight:** _________lbs.

Sex: ☐ Male ☐ Female **Marital Status:** ☐ Single ☐ Married ☐ Divorced ☐ Widow **Primary Language:**____________________

Address: ____
Street & Apartment / Suite City State ZIP

Phone **Privacy**
Home: (_____) ______ - ___________ ☐
Work: (_____) ______ - ___________ ☐
Cell: (_____) ______ - ___________ ☐
Fax: (_____) ______ - ___________ ☐

Emergency Contact **Can we discuss your care?**
Name: ______________________________ Yes ☐ No ☐
Relationship: ______________________________
Home: (_____) ______ - _____________
Work: (_____) ______ - _____________

Email ______________________________ **Preferred Method of Contact** ____________________

May we send you email correspondence? (promotions, specials, appointments) Yes ☐ No ☐

Occupation / Employer or school: ____

☐ Full Time Employment
☐ Full Time Student
☐ Retired
☐ Part Time Employment
☐ Part Time Student
☐ Other

Tell us what procedures you are interested in? ______________________________

Whom may we thank for referring you? ______________________________

PERSON FINANCIALLY RESPONSIBLE FOR ACCOUNT – If other than patient:

Legal Name: ______________________________ **Relationship:** ______________
Last Name First Name Middle

Date of Birth: _____/_____/_____ **SSN:** _______-_______-_______ **Driver's License # / State**____________________/_______

Age: ______ **Sex:** ☐ **Male** ☐ **Female** **Phone:** (______) ________ - ___________ **Work Phone:** (______) ________ - ___________

Address: ____
Street & Apartment / Suite City State ZIP

PRIMARY INSURANCE COMPANY

Insurance Company: ______________________________Phone: (_____) ______ - ___________

Claim Address: ____

Insurance Plan Type: ☐ PPO ☐ HMO ☐ POS ☐ EPO **Group #:** ____________________ **ID#:** ______________

Worker's Comp Manager: ______________________________ Phone: (_____) ______ - ___________

PRIMARY CARE PHYSICIAN: ______________________________ **Phone:** (_____) ______ - ___________

☐ **I have** a referral from my PCP ☐ **I need** a referral from my PCP