Wright Surgical Arts

COSMETIC REGISTRATION FORM

PATIENT INFORMATION

NAME________________________________ BIRTHDATE ____/_____/______ SEX: M F MARITAL STATUS: S M W D

ADDRESS____
_
(Street) (City) State) (Zip)

HOME PHONE ________________________ WORK PHONE ________________________CELL PHONE ________________________

*E-MAIL ADDRESS ____

WHO MAY WE THANK FOR REFERRING YOU TO OUR PRACTICE? ____

OCCUPATION _______________________________ EMPLOYER ____

EMERGENCY CONTACT NAME _________________ RELATIONSHIP _______________________ PHONE __________________

SPOUSE ____ HOME PHONE ________________________

SPOUSE EMPLOYER ____ WORKPHONE________________________

PHARMACY & PHARMACY TELEPHONE ____

** By providing us with your e-mail address, you authorize Wright Surgical Arts to send you periodic reminders and announcements. Your e-mail address will be used solely by Wright Surgical Arts, and we will not disclose your e-mail address to any third party. You may choose to terminate receiving e-mails from us at any time via e-mail, telephone, mail, or in person.*

RESPONSIBLE FOR BILL

NAME ____RELATIONSHIP ________________________

ADDRESS ____

HOME PHONE ___________________________ WORK PHONE _____________________________

AUTHORIZATION FOR PAYMENT

I understand that I am responsible to pay for all medical expenses. No insurance will be filed for me by Wright Surgical Arts.

____ ______________________
Patient Date

CONSENT FOR PHOTOGRAPHIC DOCUMENTATION

I consent to be photographed or imaged by computer before, during, and after the procedure. These photographs and images shall be the property of Jason Wright, DO. ***These photographs will be restricted to my medical record and may not be used for any purpose other than confidential documentation of my pre-operative and postoperative condition***. My signature below does NOT give permission to use my photograph or image for photo albums, patient education, medical education, journal publications, or any marketing medium. I understand that every effort will be made to maintain confidentiality of my identity.

____ ______________________
Patient Date