Thesiger Plastic Surgery
Dr. Paul Thesiger
Board Certified

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(Please print so this information can be accurately entered into our computer system)

Patient Information

Whom might we thank for referring you? _____

Last name: _____First name: _____ Middle _____

Address: _____

City: _____ State: _____ Zip: _____ Sex: _____

Home Phone: _____ Work Phone: _____ Ext: _____

Cell Phone: _____

Date of Birth: _____Marital Status:_____

May we contact you via email? Yes No

If so, what is your email address: _____

In case of an Emergency who should we call? _____

Relationship _____ Phone number: _____

Do you have any allergies? YES NO

If yes, what? _____

Reason for your visit today? _____

(Continued on page two)

Please do not sign if you have any concerns or questions regarding the statements listed below until that have been fully explained to you.

By signing below you:

1. You represent to Dr. Thesiger that you are at least 18 years of age, if not, you are accompanied by a legal guardian.

2. You consent to and authorize examination and/or treatment by my doctor and such assistant or staff as may be assigned by him.

3. You understand that photographs are a necessary part of planning and evaluating cosmetic and reconstructive surgery. You authorize the taking of photographs at the discretion of Dr. Thesiger and under such conditions as may be approved by him. These photographs will ONLY be used solely for documentation and educational purposes and will be kept confidential. You understand your name and/or any identification marks will not be used.

4. You guarantee prompt payment of all charges and include fees related to collection of delinquent accounts.

5. You authorize the provider rendering service to release all or part of my medical records when required for submission of any insurance claim for payment of services rendered for submission of any insurance claim for payment of services rendered. The providers, their agents, and employees who render services to me hereby released from any and all liability of the nature that may arise from the release of all or part of my medical records to other physicians should they be so requested as part of my medical care.

6. You authorize the provider rendering service and their office staff to contact you at your provided numbers and leave messages when you are unavailable as indicated.

7. The undersigned certifies that he/she has read and understands the foregoing and fully accepts terms specified above.

_____ _____

SIGNATURE / DATE **SIGNATURE OF GUARDIAN (if applicable)**

_____ _____

PRINT NAME **RELATIONSHIP TO PATIENT (if applicable)**

_____

WITNESS SIGNATURE / DATE