



Cardinal Internal Medicine
Aesthetics

REGISTRATION INFORMATION

Today's Date: _____

Date of Birth: _____

Patient's Name: (please print) _____

Patient's Address: _____
(Street/P.O Box)

(City & State)

(Zipcode)

Gender: _____ Male _____ Female

Marital Status: _____ Married _____ Single _____ Widowed _____ Divorced

Social Security Number: _____

Home Telephone: _____ Work# _____ Cell: _____

Employer: _____ Occupation: _____

Name of responsible party: _____

Relationship to patient: _____ Telephone# _____

How did you hear about Cardinal Internal Medicine Aesthetics? _____

AUTHORIZATION & PAYMENT POLICY

COST/FEES

Payment for this cosmetic procedure is my responsibility. I understand that there will be an additional fee if further treatment is needed on the second visit.

Initials: _____

FOLLOW-UP

I agree to follow-up in 2-4 weeks after my first treatment if asked to do so by my physician:

Initials: _____

PHOTOGRAPHS

I authorize the taking of clinical photograph for comparison use only. I understand my identity will be protected.

Initials: _____

The undersigned agrees to pay all charges for medical services rendered and do hereby become responsible for any uninsured balance.

Signature

Date