



Patient Information

Date: _____

(Please Print)

Patient Name: _____

Address: _____

City, State, Zip Code: _____

Email: _____

Sex: Female___ Male___ Marital Status: Single___ Married___ Divorced___ Widow___

Referred by: Wells Plastic Surgery.com Internet- Other Sites (list) _____

Yellow Pages Friend _____ Please List: _____

Physician: _____ Other: _____

Reason For Visit Today: _____

Patient's Age _____ Date of Birth: _____ SS#: _____

Phone: Home: () _____ Cell: () _____ Work: () _____

Occupation: _____ Employer: _____

Patient's Authorization:

Regardless of my insurance benefits, I understand I am financially responsible for the fees of services rendered.

*Patient Signature (guardian if minor) _____ Date: _____

I hereby authorize the above physician(s) to obtain medical records from other physicians or hospitals deemed necessary for the optimum continuity of medical care.

* Patient's Signature(guardian if minor) _____ Date: _____

Payment Policy

We are committed to providing you with the best possible care. Payment for services is due at the time services are rendered unless payment arrangements have been approved in advance by our staff. We accept cash, checks, money orders, visa, mastercard and care credit.

All surgeon fees for cosmetic procedures are due in full from the patient at least 2 weeks prior to the date of surgery. We will gladly discuss your proposed treatment and answer any questions relating to your surgery and your responsibility for the bill.
