



Acct. # _____

Patient Information (Please Print)

Date: _____

NAME	DATE OF BIRTH	AGE	SOCIAL SECURITY #	MARITAL STATUS	
STREET ADDRESS	CITY AND STATE	ZIP CODE	HOME PHONE # with area code		
EMPLOYER				BUSINESS PHONE # with area code	
OCCUPATION				CELL PHONE # with area code	
SPOUSE/ SIGNIFICANT OTHER	SPOUSE/ SIGNIFICANT OTHER'S EMPLOYER/OCCUPATION	SPOUSE/ SIGNIFICANT OTHER'S CELL PHONE # with area code			
EMERGENCY CONTACT	RELATIONSHIP				
STREET ADDRESS	CITY, STATE AND ZIP	HOME PHONE #	CELL PHONE #		
HAS ANY MEMBER OF YOUR IMMEDIATE FAMILY BEEN TREATED BY OUR PHYSICIAN(S)?				YES	NO
REFERRAL SOURCE (PLEASE FILL IN)	SEND THANK YOU?	STREET ADDRESS, CITY, STATE, & ZIP			

Email address: _____

Patient's or authorized person's signature is required. (Please read and sign.)

All professional services rendered are charged to the patient. Necessary forms will be completed to expedite insurance carrier payments. The patient is responsible for all fees, regardless of insurance coverage. It is customary to pay for surgical procedures in advance and other services when rendered unless other arrangements have been made in advance. Dr. Branman does not participate in Medicare and/or Medicaid.

I hereby authorize Dr. Branman to furnish all of my medical chart information to my insurance carrier (including, but not limited to any protected patient information, such as drug use, alcohol use, mental health records, psychiatric treatment, HIV status, or other specially protected information) concerning my treatment. I agree that I will not record, in any way, anything, which occurs in the office of Dr. Branman without prior written consent.

A doctor-patient relationship is a consensual agreed upon contractual relationship between Dr. Branman and me. Either party can agree or disagree to enter into a doctor-patient relationship. I agree that no doctor-patient relationship will be established between Dr. Branman and me until Dr. Branman has administered a definite treatment procedure to me. I agree a definite treatment procedure by definition is limited to: therapeutic injections, chemical peels, laser treatments, or direct surgical intervention. I further agree that my office consultation, surgical fee deposit, or scheduling of surgery does not constitute a definite treatment procedure or a doctor patient relationship. I agree that Dr. Branman may cancel at will any office or surgical appointment without notice or cause.

Signature _____

Date _____