Cosmetic Surgery CENTER

Acct. # _____

New Patient Information (Please Print) **ALLERGIES**_____ **Date:**

NAME	DOB / AGE	GENDER M / F	SOCIAL SECURITY #	MARITAL STATUS S M D W SEP
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		BUSINESS PHONE #	
EMERGENCY CONTACT (ALSO, MAY WE CONTACT THIS PERSON IF YOU CANNOT BE REACH?) **YES / NO**				
STREET ADDRESS	CITY, STATE AND ZIP	CELL PHONE #	WORK PHONE #	
HAS ANY MEMBER OF YOUR IMMEDIATE FAMILY BEEN TREATED BY DR. BRANMAN?			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. The patient or patient's guardian is responsible for all fees. It is customary to pay for surgical and *select* procedures in advance and other services when rendered unless other arrangements have been made in advance.

Are you on Medicaid and/or Medicare? Please circle YES / NO Dr. Branman does not participate with any insurances including Medicare/Medicaid.

I agree that I will not record, in any way, anything, which occurs in the office of Dr. Branman without prior written consent by him. 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 understand it is my responsibility to be reached by Dr. Branman and his staff when I have an upcoming surgery or procedure. I agree that Dr. Branman may cancel at will any office or surgical appointment without notice or cause.

Signature_____ **Date**_____

We request our patients update their information ANNUALLY. Please review your forms, then date and initial.

Reviewed and Updated on: _____ Patient Initials_____

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