



COSMETIC DEMOGRAPHIC FORM

PATIENT INFORMATION

Patient's Last Name:		First:	M. I.	Sex: <input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Dr. <input type="checkbox"/> Ms. <input type="checkbox"/> Miss
Street Address:			City:	State:	ZIP Code:
Home Phone No.: ()		Employer Phone No.: ()		Cell Phone No.: ()	
Preferred Phone No.: (circle one) Home / Work / Cell / Other:		Marital Status: (circle one) Single / Married / Divorced Separated / Widowed / Other		Date of Birth: / /	Social Security No.:
Email Address:			Employer:		
Emergency Contact Name			Emergency Contact Relationship	Emergency Contact Phone Number	

REFERRING INFORMATION

Referred By: (please check appropriate box)

Friend/Relative Google Ad Healthgrades Internet Ad Websites Other:

FINANCIAL ACKNOWLEDGEMENT

By signing below, I authorize treatment and agree to the following terms: 1) Fifty percent (50%) of the total amount of treatment/service is due at the time of scheduling. 2) The remaining balance is due at the time of service. 3) I understand that twenty percent (20%) of the total amount of the treatment/service is non-refundable if I choose not to proceed with the treatment/service at any time during the scheduled appointment. 4) If I cancel the appointment without giving a minimum of three (3) business days' notice, I acknowledge that twenty percent (20%) of the downpayment is non-refundable.

DISCLAIMER

By signing below, I authorize cosmetic treatment/service from the Skin Cancer & Dermatology Center and their delegated medical professional and/or provider. I recognize that outcomes are not a guarantee and may vary. I understand that individual expectations for the desired effect are subjective, and I may be disappointed with the results. I acknowledge additional treatments/services may be necessary to achieve the preferred outcomes. You may receive promotional information regarding product and service specials. To opt out check box.

Patient/Guardian Signature:	Printed Name:	Date:
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