PATIENT INFORMATION

Name (Last)____ (First)_______________________________________ (M.I.)___________

DOB:________/_________/___________ SSN:___________-__________-_______________ Gender: M F

Address:____ City:___________________________ State:___________ Zip:______________

Cell Phone: (__________) __________-______________ Home Phone: (__________) __________-______________

Email (*Required*):____

Marital Status: Single Married Divorced Separated Widowed

Employer: ____ Work Phone: (__________) __________-______________

Address:____ City:___________________________ State:___________ Zip:______________

Emergency Contact Name:____ Relationship: _________________________________

Emergency Contact Phone: (__________) __________-______________

May we leave medical information with this person if you are not available? YES NO

INSURANCE POLICY HOLDER INFORMATION

Policy Holder Name (Last)____ (First)__________________________________ (M.I.)__________

DOB:________/_________/___________ SSN:___________-__________-_______________ Gender: M F

Relationship to Patient:_____________________________________

Address:____ City:___________________________ State:___________ Zip:______________

Employer:____ Work Phone: (__________) __________-______________

PREFERRED PHARMACY AND LOCATION:____

How did you hear about us? *(circle)*

Doctor Magazine/Paper Billboard Email TV Facebook/IG Online:______________ Friend/Family:_________________

What are you consulting for today? *(circle)*

Stem Cell/PRP SmartLipo Fat Transfer CoolSculpting Laser Injectables HydraFacial General Other

CONSENT

I confirm that all information above is true and I hereby authorize treatment of the above named patient and agree to pay all charges for treatment regardless of insurance coverage or any pending insurance claims. I authorize the release of all my medical information pertinent to my medical care and necessary to process my insurance claims. I also authorize the release of my personal test results to my possession. I will assign all medical benefits to SouthPointe Family Physicians. A photocopy of this form shall be as valid as the original. I understand that I can withdraw this medical consent at any time by notifying this office in writing. I also agree with the HIPPA statement as presented to me in writing. I have read this information and understand it thoroughly.

Patient Signature:____ *Date*: _________/__________/___________
(If patient is 19 years of age or older)

Legal Guardian Signature:____ *Date*: _________/__________/___________
(If patient is 18 years of age or younger)