

Raval Facial Aesthetics & ENT, PC
Personal Information

Date _____

First Name _____ Last Name _____ Middle Initial _____

Preferred Name _____ Address _____

City, State, Zip _____

Home Phone _____ Work Phone _____ Cell Phone _____

Male Female Minor Single Married Domestic Partner

Birth Date _____ Social Security # _____

Employer _____ Occupation _____

Who may we thank for referring you to our office? _____

E-mail Address _____

How do you prefer to be contacted? E-mail Phone Text Message

Emergency Contact _____ Phone _____

Responsible Party

Who is responsible for the account? _____

Name _____

Relationship to Patient _____ Birth Date _____ Driver's License # _____

Social Security # _____ E-mail Address _____

Address _____

City, State, Zip _____

Employer _____ Occupation _____

Please tell us about your concerns: _____

What specifically do you wish to have corrected? _____

Have you had any previous treatments done for this area? Yes No

If yes, please describe: _____

Date of Treatment: _____

Consent:

I understand that responsibility for payment of medical services in this office for myself and my dependents is mine, due and payable at the time of services are rendered unless financial arrangements have been made. I understand that I am responsible for all costs of collection including attorney fees, collection fees and court costs. I understand that any unpaid balance will be assessed interest at the rate of 18.00% (1.5% monthly). I also assign all benefits to Name of Provider. I understand that 3.00% fee will be added to any credit card payment collected by the provider's office or its collection agency. I give my authorization and consent for treatment after having a full explanation of proposed treatment, alternatives, and risks by my doctor. I have been advised of my privacy rights as provided by the Healthcare Information Portability and Accountability Act of 1996.

Responsible Party's Signature _____ Date _____