Perfecting your natural beauty

Gallas plastic surgery & vein center

Patient's Name _____

Last First Middle

Address _____

Street & Apt # City State Zip

Home Phone _____ Cell Phone _____ Other Phone _____

Email _____ DL #: _____

Is it okay to contact you via email with appointment reminders and special events? ❒ Yes ❒ No

Restrictions for contacting patient? ❒ Yes ❒ No Contact Restrictions _____

Age _____ Birthdate _____ Sex ❒ Female ❒ Male

Marital Status: Single ❒ Married to _____ ❒ Other _____

Patient's Employer _____ Occupation _____

Work Phone _____ Ext _____ Is it okay to call you at work? ❒ Yes ❒ No

Emergency Contact Information

Name _____ Relationship to patient _____

Home Phone _____ Cell Phone _____ Other Phone _____

Address _____

Reason(s) For Visit _____

How did you hear about Gallas Plastic Surgery & Vein Center? _____

Other areas of interest include:

Breast	Arms/ Back	Face	Forehead	Abdomen Hips/ Thighs/ "Love Handles"
Neck	Nose	Eyes	Leg Veins	Facial Lines/ Wrinkles

Would you like a complimentary consultation with our medical aesthetician to discuss:

❒ Yes ❒ No

Facial Veins/ Redness	Acne	Sun Damage	Uneven Skin Tone
Laser Hair Removal	Chemical Peels	IPL Photofacial	Skin Care Products

I understand that office visit charges are payable on the day service is rendered. I authorize Dr. Gallas to bill my insurance company, if necessary. Regardless of insurance coverage, I am responsible for all bills to be in a timely manner. I understand that my contract is between Dr. Gallas and myself.

As a courtesy, we ask that you cancel 24 hours in advance if you are unable to make a scheduled appointment. We reserve the right to charge you up to 50% of the treatment total for repeated last minute cancellations or missed appointments.

Patient Signature _____ **Date** _____