PATIENT INFORMATION

Patient Name ____

Last First Middle

Address ____

Street & Apt # City State Zip

Home Phone ______________ Cell Phone ______________ Other Phone ______________

Email ________________________________ DL #: ______________

May we contact you via email with appointment reminders and special events? Yes No

Restrictions for contacting patient? Yes No Contact Restrictions ______________________

Age _______ Birthdate __________ Gender: Female Male

Marital Status: Single Married Other Spouse's name______________________

Pharmacy Name ______________ Pharmacy Phone Number______________________

Pharmacy Address____

Patient Employer ________________________ Occupation ______________________

Work Phone ______________ Ext _______ May we contact 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? ________________________________

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

Initials ________ 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 charges to be paid in full. I understand that my contract is between Dr. Gallas and myself.

Initials________ I understand that if I am unable to make a scheduled appointment, Gallas Plastic Surgery reserves the right to charge me up to 50% of the appointment or treatment price.

X ____ ______________

Signature of Patient or Parent, if Minor Date