



PATIENT INFORMATION
INTAKE FORM for MEDICAL COSMETIC TREATMENT

Last Name _____ First Name _____ MI _____

Date of Birth ___/___/___ Age ___ Sex _____ S.S.# _____

___ Single ___ Married ___ Widowed ___ Divorced

Address _____

City _____ St _____ Zip _____

Telephone _____ Cell _____

Occupation _____ Employer _____

Work Telephone _____ Email _____

Contact me at: Home? ___ By Email? ___ By cell phone? ___ At work? ___

Name of Spouse _____ Telephone _____
(or emergency contact)

My Patient Information may be released to: _____

From where did you hear about our office?

___ Referral (by: _____) ___ KTVB.com

___ Google Search ___ LACI.com ___ Channel 7 KTVB

___ Idahosmartlipo.com ___ Eaglesmartlipo.com ___ RMGHC.com

___ Other: _____

Patient Signature: _____ Date: _____