Phone: 817-614-3677
Fax: 817-288-0550
www.davincilasercenter.com

Patient Information

________________________ Patient Name (PRINT)	____/____/____ Date of Birth	M F Circle Sex of Patient	____/____/____ Today's Date

______________ Address	Apt. #	City	State	Zip

(please mark the box next to each phone number indicating whether or not the physician or staff may leave a message)

( ) _____ - __________ ❑❑ Home Phone Y N	( ) _____ - __________ ❑❑ Work Phone Y N	( ) _____ - __________ ❑❑ Alt./Cell Phone Y N	( ) _____ - __________ EMERGENCY CONTACT #
______________ Social Security Number	M S W D Minor Marital Status (please circle)	______________ Primary Care Physician	______________ EMERG. CONTACT NAME
______________ Occupation	______________ Employer	______________ E-mail Address	

Who may we thank for your visit? (please circle and list) Physician / Friend ________________________________

____

Please read and sign the following consent for examination and treatment:

I am at least 18 years of age, or, if not am accompanied by a legal guardian. I understand the need for such information contained herein to be updated annually. I understand that photography is at times a necessary part of planning and evaluating treatment, and hereby authorize the taking of photographs at the direction of the physician and/or delegate solely for documentation purposes and recognize they will be kept confidential unless otherwise disclosed. I understand I am ULTIMATELY responsible for payment of services rendered. I hereby give the physician/staff at DaVinci Laser Centers authorization for EXAMINATION and TREATMENT.

______________________ Signature	PATIENT SPOUSE PARENT GUARDIAN Relationship (please circle)	_____/_____/_____ Date