THE PALM BEACH CENTER
for Facial Plastic & Laser Surgery

PATIENT DEMOGRAPHIC SHEET

Appointment date: _____

Patient name: _____ D.O.B _____ Age: _____

Address: _____ City: _____ State: _____ Zip: _____

SS#: _____

CONTACT INFORMATION:

May we contact your cell phone? _____ YES _____ NO Cell Phone: _____

May we contact you at home? _____ YES _____ NO Home Phone: _____

If yes, may we leave a message? _____ YES _____ NO

May we contact you at work? _____ YES _____ NO Work Phone: _____ Ext:____

May we contact you via email? _____ YES _____ NO Email address: _____

_____ I am interested in learning about special events and exclusive offers.

Employer: _____ Occupation: _____

Employer address: _____ City:_____ State:_____ Zip:_____

Emergency contact person: _____ Relationship: _____

Contact address: _____ City:_____ State:_____ Zip:_____

Home phone: _____ Cell phone: _____ Work phone: _____

Family physician: _____ Phone: _____

Dermatologist: _____ Phone: _____

Who referred you to us? Please check any and all that apply.

___ Physician
Name: _____

____ Word of mouth/Friend/Staff member
Name: _____

_____ Print Publication
Title: _____

____ Online
___ Internet search ___ Other website: _____

_____ Seminar
Title/Topic: _____

(Please turn over)

INSURANCE INFORMATION ~ REQUIRED

Policy holder's name: _____ Relationship: _____

Name of insurance: _____

Contract #: _____ Group #: _____ Contact person: _____

Insurance address: _____ City: _____ State:_____ Zip:_____

Insurance phone: _____

FISCAL POLICIES

It is the policy of The Palm Beach Center for Facial Plastic and Laser Surgery that payment for all office services are due on the date of service. We accept various forms of payment including cash, personal check, money orders, Visa, Mastercard, Discover, and American Express. According to standard practice, full payment for cosmetic surgery is required three weeks in advance of surgery.

Cancellation of appointments must be made 48 hours prior to scheduled date or service fees will be charged to the patient.

I authorize payment of medical benefits to Jean-Paul Azzi, M.D. for services rendered and release any medical information necessary to process the payment claim.

_____ _____

Signature of Insured or Authorized Person Date