

LAURENCE WEIDER, M.D.
7777 FOREST LANE
SUITE B-145
DALLAS, TX 75230

Cosmetic Patient Demographics

Appointment date _____

Referred by: _____

Reason for visit _____

Please check as many as apply.

- www.drweider.com
- www.breastimplants411.com
- www.lookingyourbest.com
- www.implantforum.com
- Other _____

- MSN.com
 - Google.com
 - Yahoo.com
 - Former patient or friend
- Name of person: _____

Last Name _____ First Name _____ Initial _____ Home# _____

Address _____ Sex M F _____ Cell# _____

City _____ State _____ Zip _____ Work# _____

S.S.# _____ Age _____ D. O. B. ____/____/____ leave a message? Y N

S M W D Spouse Name _____

E-Mail Address _____ May we send you an e-mail? Y N

Employer _____ Occupation _____

Address _____ City _____ State _____ Zip _____

Emergency contact _____ Phone _____

Nearest relative not living with you _____ Phone _____

If Patient is a Minor:

Responsible person _____ Relation to patient _____

Home Phone # _____ Work Phone # _____

PAYMENT IS DUE AT THE TIME SERVICES ARE RENDERED WITH NO EXCEPTION. I AUTHORIZE DIRECT PAYMENT OF MEDICAL BENEFITS TO BE MADE TO LAURENCE WEIDER, M.D. ON MY BEHALF FOR ANY SERVICES RENDERED TO ME. SOME SERVICES RENDERED BY LAURENCE WEIDER, M.D. MAY NOT BE COVERED BY MY INSURANCE. I UNDERSTAND IT IS MY RESPONSIBILITY FOR PAYMENT OF SUCH SERVICES REGARDLESS OF ANY INSURANCE COVERAGE I MAY HAVE. I AUTHORIZE DR. WEIDER TO FURNISH MY INSURANCE COMPANY(S) ANY RECORDS REQUESTED BY THEM.

Date ____/____/____

SIGNATURE OF PATIENT OR GUARDIAN

How will you be paying for today's visit? Cash Credit Card /Debit Check

Acknowledgement of Review of Notice of Privacy Practices

I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

Signature of Patient or Personal Representative

_____ Date

Name of Patient or Personal Representative

Description of Personal Representative's Authority