

**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.

- drweider.com
- realself.com
- breastimplantsusa.com
- loveyourlook.com
- Other \_\_\_\_\_

- Google.com
- Bing.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