

**MICHAEL M. PAPALIAN, MD**  
PLASTIC AND RECONSTRUCTIVE SURGERY  
AESTHETIC SURGERY

PATIENT NAME \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_ AGE \_\_\_\_\_

ADDRESS \_\_\_\_\_ HOME PHONE (\_\_\_\_) \_\_\_\_\_  
STREET \_\_\_\_\_

CELL PHONE (\_\_\_\_) \_\_\_\_\_

\_\_\_\_\_  
CITY, STATE, ZIP CODE **E-MAIL ADDRESS** \_\_\_\_\_

PATIENT'S SOCIAL SECURITY # \_\_\_\_\_ MARITAL STATUS \_\_\_\_\_

IF PATIENT IS A **MINOR**: GUARDIAN'S NAME \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_

EMPLOYER \_\_\_\_\_ OCCUPATION \_\_\_\_\_

EMPLOYER ADDRESS \_\_\_\_\_ BUSINESS PHONE (\_\_\_\_) \_\_\_\_\_

\_\_\_\_\_  
CITY, STATE, ZIP CODE

NAME OF SPOUSE \_\_\_\_\_ SPOUSE'S SOC SECURITY # \_\_\_\_\_

SPOUSE'S EMPLOYER \_\_\_\_\_ BUSINESS PHONE: (\_\_\_\_) \_\_\_\_\_

**NOTE: PREFERENCES FOR CONTACT** HOME PHONE \_\_\_\_\_ WORK PHONE \_\_\_\_\_ CELL PHONE \_\_\_\_\_ E-MAIL \_\_\_\_\_

NAME OF **REFERRING DOCTOR** OR **PATIENT** \_\_\_\_\_

NAME OF YOUR **PRIMARY CARE** PHYSICIAN \_\_\_\_\_

**REASON FOR INITIAL VISIT** \_\_\_\_\_

**PHOTOGRAPH RELEASE:** I UNDERSTAND THAT PHOTOGRAPHS MAY BE TAKEN OF ME AS PART OF MY ROUTINE CARE BY DR. PAPALIAN AND THAT THESE PHOTOGRAPHS WILL BECOME PART OF MY MEDICAL RECORD AND MAY BE USED FOR INSTRUCTIONAL PURPOSES. I HEREBY GIVE PERMISSION FOR THESE PHOTOGRAPHS TO BE TAKEN, INCLUDED IN MY MEDICAL RECORD AND USED FOR INSTRUCTIONAL PURPOSES. I ALSO GIVE PERMISSION FOR PHOTOGRAPHS TO BE UTILIZED FOR PROMOTIONAL PURPOSES AND/OR MEDICAL PUBLICATIONS. I UNDERSTAND THAT MY NAME WILL **NOT** ACCOMPANY ANY PUBLISHED PHOTOGRAPH.

**SIGNED:** (PATIENT OR GUARDIAN, IF MINOR) \_\_\_\_\_ **DATE:** \_\_\_\_\_

RENDERED **FINANCIAL RESPONSIBILITY:** I UNDERSTAND THAT I AM RESPONSIBLE FOR PAYMENT OF SERVICES HERE BY DR. MICHAEL PAPALIAN AND THAT I AM FINANCIALLY RESPONSIBLE FOR NON-INSURANCE COVERED OR NON-AUTHORIZED INSURANCE SERVICES RECEIVED.

**SIGNED:** (PATIENT OR GUARDIAN, IF MINOR) \_\_\_\_\_ **DATE:** \_\_\_\_\_

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