

MICHAEL M. PAPALIAN, MD
Plastic and Reconstructive Surgery
www.drpapalian.com

PATIENT NAME _____ DATE OF BIRTH _____ AGE _____

ADDRESS _____ HOME PHONE (____) _____
STREET _____

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:** _____

FINANCIAL RESPONSIBILITY: I UNDERSTAND THAT I AM RESPONSIBLE FOR PAYMENT OF SERVICES RENDERED 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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