DEVLIN
COSMETIC SURGERY

Acct#_____

Michael A. Devlin, MD

Patient Name:_____

First Middle Initial Last

Address:_____

City:_____ **State**:_____ **Zip**:_____

Marital Status: S M D W SEP **Sex**: Male Female

Date of Birth:_____ **Social Security#** _____

Employer:_____ **Occupation:** _____

Spouse's Name:_____ Phone#_____ Occupation_____

Emergency Contact_____

Name Phone Number

Home Phone:_____ **Can we leave a message for you at home?** Yes No

Work Phone:_____ **Can we leave a message for you at work?** Yes No

Cell Phone: _____ **Can we send you a text message?** Yes No

Email Address: _____

Preferred method of contact: Home Work Cell Email

May we send you written communication to the address listed above: Yes No

Referral Source: **___ Website** **_____KATV channel 7** **_____THV channel 11** **_____Healthbeat** **Radio_____**

Referral Source: My **Friend/Relative** recommended you_____ May we send a Thank You? Yes No

Name

Patient's or authorized person's signature is required. (Please read and sign)

A doctor patient relationship is a consensual agreed upon contractual relationship between Dr. Devlin and me. Either party can agree or disagree to enter into a doctor-patient relationship. I agree that no doctor patient relationship will be established between Dr. Devlin and me until Dr. Devlin has administered a definite treatment procedure for me. I agree a definite treatment procedure by definition is limited to therapeutic injections, chemical peels, laser treatments, or direct surgical intervention, I further agree that my office consultation, surgical fee deposit, or scheduling of surgery does not constitute a definite treatment procedure or a doctor patient relationship. Dr. Devlin does not participate in Medicare and/or Medicaid.

Signature_____ **Date**_____