

**Devlin Cosmetic Surgery
Michael A. Devlin, MD**

Acct. # _____

New Patient Information (Please Print)

Date: _____

NAME	DATE OF BIRTH	AGE	SOCIAL SECURITY #	MARITAL STATUS S M D W SEP
STREET ADDRESS	CITY AND STATE		ZIP CODE	HOME PHONE # with area code
EMPLOYER				BUSINESS PHONE # with area code
OCCUPATION				CELL PHONE # with area code
SPOUSE	SPOUSE'S EMPLOYER/OCCUPATION			BUSINESS PHONE #
EMERGENCY CONTACT				
STREET ADDRESS	CITY, STATE AND ZIP		HOME PHONE #	CELL PHONE #
HAS ANY MEMBER OF YOUR IMMEDIATE FAMILY BEEN TREATED BY OUR PHYSICIAN(S)?				YES NO
REFERRAL SOURCE (PLEASE FILL IN)	SEND THANK YOU?	STREET ADDRESS, CITY, STATE, & ZIP		

Email address: _____

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

All professional services rendered are charged to the patient. Necessary forms will be completed to expedite insurance carrier payments. The patient is responsible for all fees, regardless of insurance coverage. It is customary to pay for surgical procedures in advance and other services when rendered unless other arrangements have been made in advance. Dr. Devlin does not participate in Medicare and/or Medicaid.

I hereby authorize Dr. Devlin to furnish all of my medical chart information to my insurance carrier (including, but not limited to any protected patient information, such as drug use, alcohol use, mental health records, psychiatric treatment, HIV status, or other specially protected information) concerning my treatment. I agree that I will not record, in any way, anything, which occurs in the office of Dr. Devlin without prior written consent by Dr. Devlin.

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 to 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. I agree that Dr. Devlin may cancel at will any office or surgical appointment without notice or cause.

Signature _____ **Date** _____