Welcome To Our Office

PLEASE PRINT AND COMPLETE ALL PARTS

Aesthetic Surgery & Dermatology
Adrienne Stewart Doctor of Medicine
of Cherry Creek

Today's Date ____________________

PATIENT NAME: (This section refers to Patient Only) PLEASE PRINT **(PLEASE CHECK ONE)**

Last Name _____________________ First Name ______________________ Middle Initial _______ ❑ Single ❑ Married ❑ Divorced ❑ Widowed

Address ____ City _______________________ State _______ Zip _____________

Home Phone _______________________________ Cell _________________________________ Work _________________________________

Email Address ____ Employer ____

Date of Birth _____________ Age _____ Sex _____ Social Security # ______________________ Occupation ____________________________

Spouse_________________________________ Employer ______________________________ Work Phone ____________________________

Relationship to Responsible Party ❑ Self ❑ Spouse ❑ Son ❑ Daughter ❑ Other

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RESPONSIBLE PARTY: (Person who should receive the bill)

Name ____ Employer _____________________________________

Address ____ City ____________________________ State_________ Zip ______________

Home Phone ______________________________ Work Phone _______________________________ Social Security #_________________________

How did your hear about us?____

Referring Physician Name (PCP) ____ **Phone** ____________________________________

MEDICAL HISTORY (Please complete thoroughly.)

Please list any past or current medical problems for which you have been treated ____

____

Allergies ____

_

Please list any current medications you are taking ____

Do you smoke YES / NO ? How much? ___________________ Do you drink YES / NO / OCCASIONALLY? How Much? __________________

NOTIFY IN EMERGENCY (NOT LIVING WITH YOU) ____

CONSENT FOR TEST RESULTS I give Aesthetic Surgery & Dermatology of Cherry Creek permission to leave all X-ray, lab results, test results and other medical information and advice on (Check all that apply)

❑ Voice mail at work ❑ Answering machine at home ❑ Other______________________________________ ❑ Do not leave a message

I hereby acknowledge that I received a copy of Aesthetic Surgery & Dermatology of Cherry Creek Notice of Privacy Practices. I authorize the release of any medical information and payment of medical benefits to the undersigned physician or supplier for services necessary to process a claim. I agree to be responsible for any deductible, co-insurance, co-pay, or any other balance not paid by my insurance.

Patient Name (PLEASE PRINT) ____ Date _____________________

Signature ____Relationship to patient (check one) ❑ Self ❑ Parent ❑ Guardian