DOUGLAS M. STEVENS, MD

PERSONAL INFORMATION

Today's Date: _____ Account #: _____ SSN: _____

First Name: _____ MI: _____ Last Name: _____

Address: _____

Zip Code: _____ City: _____ State: _____

Date of Birth: _____ AGE _____ Marital Status: _____

Sex: _____ May we leave information on your answering machine or voicemail? ☐ Yes ☐ No

Home Phone: _____ Cell Phone: _____ Preferred: ☐ Home ☐ Cell

Would you prefer that your appt confirmation is text messaged?
☐ Yes ☐ No

Email: _____

Occupation: _____ Work No: _____ Employer: _____

In the event of an emergency please contact:

Name: _____ Relationship: _____ Phone No: _____

How did you hear about our office? ☐Newspaper ☐Family ☐Friend ☐Phone Book ☐Radio ☐Website

Have you visited our website www.douglasstevensmd.com ? ☐ Yes ☐ No

May we contact you for special events or practice information? ☐ Yes ☐ No ☐ By email ☐ By cell phone

Photos will be taken as part of my treatment here. I give my permission to use these photos for seminars and other patient education purposes including use on the practice's website. ☐ Yes ☐ No

Signature: Date:

What concerns regarding your appearance would you like to discuss today?

What motivates you to pursue our services at this time?

Have you ever had cosmetic surgery before? ☐ Yes ☐ No What procedures were done and when was it performed?

Are you in good health?

Do you currently smoke?
Have you ever smoked?

NOTICE REGARDING PAYMENTS:

For all other patients, payment is required at the time of service. We will provide you with the necessary documentation to file for reimbursement upon your request. Filing with secondary insurances is the patient's responsibility. A $20.00 returned check fee will be charged for returned checks. A $50.00 fee will be charged for missed appointments without 24 hour notice.

NOTICE REGARDING MALPRACTICE COVERAGE:

I understand that Florida law generally requires that physicians carry medical malpractice insurance or other wise demonstrate financial responsibility to cover potential claims for medical malpractice. I further understand that Florida law imposes strict penalties against non-insured physicians who fail to satisfy adverse judgments arising from claims of medical malpractice. I understand that Dr. Stevens has elected pursuant to Florida law not to carry medical malpractice insurance. I understand that this election is permitted under Florida law, subject to certain conditions, and understand that I have been provided with notice of this election pursuant to Florida law.

I have read and understand the above information. I understand that I am responsible for payment for services I receive.

PATIENT SIGNATURE: _____ **DATE:** _____