

Perfecting your natural beauty



Patient's Name _____

Last First Middle

Address _____

Street & Apt # City State Zip

Home Phone _____ Cell Phone _____ Other Phone _____

Email _____ DL #: _____

Is it okay to contact you via email with appointment reminders and special events? Yes No

Restrictions for contacting patient? Yes No Contact Restrictions _____

Age _____ Birthdate _____ Sex Female Male

Marital Status: Single Married Other _____ Spouse's Name _____

Patient's Employer _____ Occupation _____

Work Phone _____ Ext _____ is it okay to call you at work? Yes No

Emergency Contact Information

Name _____ Relationship to patient _____

Home Phone _____ Cell Phone _____ Other Phone _____

Address _____

Reason(s) For Visit _____

How did you hear about Gallas Plastic Surgery & Vein Center? _____

Other areas of interest include:

- Breast Arms/ Back Face Forehead Abdomen Hips/ Thighs/ "Love Handles"
Neck Nose Eyes Leg Veins Facial Lines/ Wrinkles

Would you like a complimentary consultation with our medical aesthetician to discuss:

- Facial Veins/ Redness Acne Sun Damage Uneven Skin Tone
Laser Hair Removal Chemical Peels IPL Photofacial Skin Care Products

Yes No

Initials _____. I understand that office visit charges are payable on the day service is rendered. I authorize Dr. Gallas to bill my insurance company, if necessary. Regardless of insurance coverage, I am responsible for all charges to be paid in full. I understand that my contract is between Dr. Gallas and myself.

Initials _____. As a courtesy, we ask that you cancel 24 hours in advance if you are unable to make a scheduled appointment. We reserve the right to charge you up to 50% of the treatment total for repeated last minute cancellations or missed appointments.

Patient Signature _____

Date _____