Patient Name (Last, First, Middle Initial): _____

Nickname: _____ **Sex:** _____

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

Marital Status: _____

Contact Information: (Please Circle **BEST** way of communication)

Cell #: _____ **Home #:** _____ **Business #:** _____

Email: _____

Address (Street, City, State, Zip): _____ _____ _____

Occupation: _____ **Referred by:** _____

Are you here for: (Please Circle) Oral Surgery* or Cosmetic Surgery?** _____

Please list reason: _____

***Oral Surgery Patients: Are you interested in a complimentary skin assessment/Consultation?** _____

****Cosmetic Patients: Describe anything that bothers you about your physical appearance that you would like to address.**

_____

Please send all statements and financial account inquires to:

Name: _____ **DOB:** _____ **Social Security #:** _____

Address (Street, City, State, Zip): _____ _____ _____

Signature of Person Responsible for Account: _____

Emergency Contact Information (Name & Relation) _____

Cell #: _____ **Home #:** _____ **Business #:** _____

AUTHORIZATION AND RELEASE FOR SERVICES RENDERED

I authorize the physician or healthcare professional (interdisciplinary team members) to perform diagnostic procedures and treatment as necessary for proper surgical care. I authorize the taking of photographs, radiographs, and other diagnostic records before, during, and after treatment. This information can__ or cannot __ be used by the doctor for scientific presentation or literature. I authorize Virginia Surgical Arts to release any information including the diagnosis and records of any treatment or examination rendered to me/my child during the period of such dental/medical care to third party payers, other entities and/or health practitioners.

The above information is accurate and complete to the best of my knowledge.

Patient or Parent/Guardian Signature: _____ **Date:** _____