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Website:
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How did you hear about Kalos Facial Plastic Surgery?

Internet

Media Ad

YellowPages

Physician:

Name

Family/Friend:

Name

Hospital:

Name

(For Office use only) Chart #: _____

Patient Information

Date: _____

Patient Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____

Name of Employer: _____ Email: _____

Date of Birth: _____ Age: _____ Sex: M F

Marital Status: Single Married Widowed Other

Emergency Contact: _____ Phone: _____

Relationship: _____

Physician Information:

Referring Physician: _____ Location: _____

Family Physician: _____ Location: _____

Primary Insurance Policy Holder Information (If you have Medicare you are the policy holder)

Primary Ins.: _____ ID #: _____

Insured Name: _____ SS#: _____

Relationship: Self Spouse Child Other _____

Secondary Insurance Name: _____

I hereby consent to treatment of myself, my child or the above minor, for whom I accept responsibility, the release of medical information to any insurance carrier or direct payment to Kalos Facial Plastic Surgery for any treatment or examination rendered is authorized. I hereby acknowledge and accept final responsibility for payment or charges for medical services rendered.

Signature of Patient or Authorized Person

Date

SIGNATURE IS REQUIRED FOR TREATMENT