

PATIENT INFORMATION

Legal Name: _____
(Last) Mr. Mrs. Ms. (First) (Middle)

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

Phone: (____) _____ (____) _____ (____) _____
Home Work Cell

May we call/leave messages at home, work, and cell? Y / N Preferred contact method: Home / Work / Cell/ Email

E-Mail Address: _____

Date of Birth: ____/____/____ Age: _____ M / F SS# _____ - _____ - _____

Status (circle one) Single /Married /Divorced /Widow Spouse, Parent, or Guardian (circle one) Name: _____

Patient's Employer or School: _____ Occupation: _____

How did you hear about Dr. Poole? _____

Reason for Visit/Procedure of

Interest: _____

PERSON RESPONSIBLE FOR BILL

Legal Name (if different from above): _____
(Last) Mr. Mrs. Ms. (First) (Middle)

Relationship to Patient: _____

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

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

Date of Birth: ____/____/____ Age: _____ SS# _____ - _____ - _____

Phone: (____) _____ (____) _____ (____) _____
(Home) (Work) (Cell)

AUTHORIZATION FOR EXAMINATION AND TREATMENT

I represent to the physician and staff that I am at least 18 (eighteen) years of age or, if not, am accompanied by a legal guardian. I hereby consent to and authorize examination and treatment by Dr. Poole or such assistant(s) or staff as may be assigned by him. I understand that the taking of photographs is a necessary part of surgical/medical evaluation and planning as well as patient education, and I authorize Dr. Poole and his staff to take and use these photographs for these purposes. In the event that authorization for surgery is requested from my insurance company, necessary photographs may be released to them. A copy of this authorization shall be considered as valid as the original and shall remain in force until I rescind these authorizations.

SIGNATURE: _____ DATE: _____
Relationship: (circle one) Patient Spouse Parent Guardian