

Chart # _____

Richmond Surgical Arts, Inc.

Gregory T. Lynam, M.D., D.D.S.

[PLEASE PRINT AND FILL OUT THE FORM COMPLETELY]

Patient's Name: _____ Sex: M F
Last First Middle

Patient's Address: _____
Street & Apt. # City State Zip

Home Phone: _____ Cell Phone: _____

Date of Birth: ____/____/____ Age: _____

Marital Status: Single Married Divorced Partner Widowed

Would you like to receive email updates about products, specials, etc.? Yes No
Email address: _____

EMERGENCY CONTACT

Person to notify in case of an emergency: _____ Relationship: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

EMPLOYMENT INFORMATION

Employer: _____ Occupation: _____

Address: _____ Work Phone: _____

Spouse's/Partner's Name: _____ Employer: _____

Address [if different from above]: _____

Work Phone: _____

HOW DID YOU HEAR ABOUT DR. LYNAM? [Please check all that apply.]

- My family member/friend _____ told me about Dr. Lynam.
- Dr. _____ referred me.
- I wanted to see a Board Certified Plastic Surgeon.
- I saw a commercial for Dr. Lynam.
- www.richmondsurgicalarts.com or the internet _____ [specific site]
- Other: _____

What brings you in today? Let us know the primary reason for your visit. _____

I understand that I am financially responsible for all charges. I also agree that in the event that my account must be turned over to an attorney for collection that I will be responsible for attorney's fees, court costs, and interest.

Signature

Date