Richmond Surgical Arts, Inc.

The Skin Rejuvenation Center

Gregory T. Lynam, M.D

[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

Preferred Contact Phone #:________________________**Email address:**________________________

Date of Birth:____/____/____ **Age:**______ **Marital Status:** ☐Single ☐Married ☐Divorced ☐Partner ☐Widowed

How did you hear about Richmond Surgical Arts, Inc.?________________________________

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

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EMERGENCY CONTACT

Person to notify in case of an emergency: ____________________ **Relationship:**______________

Home Phone:______________ **Cell Phone:**______________ **Work Phone:**______________

EMPLOYMENT INFORMATION

Employer:________________________________**Occupation:**______________

Address:________________________________**Work Phone:**______________

IF PATIENT IS A MINOR, PLEASE PROVIDE THE FOLLOWING INFORMATION:

Father's name:________________________ **Mother's name**________________________

Employer:________________________ **Employer:**________________________

Work phone:________________________ **Work phone:**________________________

I understand that all charges are due at the time of my appointment.

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Signature **Date**