<u>Marc Malek, M.D</u>
Aesthetic Plastic and Reconstructive Surgery
8994 E. Desert Cove Avenue Ste. 100
480-551-2040 (phone), 480-889-0704 (fax)

PATIENT INFORMATION

Last Name:	**First Name:**	
Street Adress:		
City:	**State:**	**Zip:**
How did you hear about us? (circle one) Yellow pages /Patient Referral / Dr. Refferal / Ad / Seminar		
E-mail Address:		
Date of Birth:	**Home Phone:**	**Cell Phone:**
SSN:	**Reason for Visit:**	
Patient's Employer:		**Occupation:**
Employers Phone:		**Can We Contact You At Work: Yes / No**

FAMILY

Spouse/Legal Guardian:	**Relationship to Patient:**
Spouse/Guardian Employer:	**Phone of Employer:**

We accept Cash/Cashier Checks/Money Orders/Visa/AMEX Mastercard. Finance options are also available.

INSURED PATIENTS: Please provide our office with a signed and completed form. In selective situations, we may file your claim to your insurance company. Your policy is a contract between you and your insurance company and any services not covered or inadequately covered by your policy will be your responsibility. Please note that this office is not bound by the usual and customary fees provided by insurance companies.

INSURED OR AUTHORIZED PERSON'S SIGNATURE: I authorize the release of any medical or other information necessary to process this claim.

PHOTO CONSENT: I authorize Dr. Marc Malek M.D to take photos of me prior to and after any procedure. I understand that these photos are the property of the office and will not be used for any publication without special written consent by me.

Signature: Date: