**JAMES M. NACHBAR, MD, FACS, PC**
**COSMETIC PATIENT**

DATE ____________________ SSN # ____________________________ DATE OF BIRTH_____________

NAME ____________________________________________________________________________
Last First M.I.

ADDRESS __________________________________________________________________________

____________________________________________________________ MALE ______ FEMALE _______
City State Zip

HOME PHONE __________________________________ WORK PHONE ______________________________

MOBILE PHONE ____________________ EMAIL ADDRESS ________________________________________

MARITAL STATUS: Single ____ Married_____ Divorced _____ Widowed_______

WHERE DID YOU HEAR OF US? _________________________________________________________________

EMPLOYER NAME_____________________________________________________________________________

EMPLOYER ADDRESS__________________________________________________________________________

__________________________________________________________________________________________
City State Zip

In case of Emergency, Contact_____________________________________________________________________

Address___________________________________________________________________________________________

__________________________________________________________________________________________
City State Zip

Home Phone___________________________________Work Phone________________________________________

I understand that I am responsible for payment of the medical bills for the patient named above incurred with James M. Nachbar, MD, FACS, PC (JMN). I understand that Insurance, including Medicare, does not cover cosmetic surgery. In order to provide the highest level of care at the most reasonable cost, JMN does not participate in any insurance plans, and our prices do not include charges for insurance paperwork. JMN charges $100 for each letter or billing document prepared for an insurance company. I also understand that, should revision after cosmetic surgery be required, I will be responsible for any anesthesia and operating room charges for the revision. If Dr. Nachbar's surgery is secondary after that of another surgeon, there will also be a surgeon's fee for additional procedures because of the complexity of these secondary cases. To assist in the continuity of care, I agree to the release of my medical information to my other health care providers.

Patient Signature____________________________________________________________Date____________________