AUSTIN-WESTON CENTER FOR COSMETIC SURGERY

Patient Information Form **Provider:**

Patient Name: _____ Nickname: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Cell Carrier: _____

Work Phone: _____ Gender: _____

DOB: _____ Age: _____ Marital Status: _____

SSN: _____ Email Address: _____

Who is your primary care physician? _____

How did you hear about our clinic?

- ☐ Washington Post Magazine
- ☐ Washington Post Cover Wrap
- ☐ Virginia Living Magazine
- ☐ Northern Virginia Magazine
- ☐ Washingtonian Magazine
- ☐ Washington Home and Design
- ☐ Washington City Paper
- ☐ Capitol File Magazine
- ☐ FW (Fashion Washington)
- ☐ Architectural Digest

Please provide name (if applicable):

- ☐ Patient Referral: _____
- ☐ Friend: _____
- ☐ Dr. Referral: _____
- ☐ Newspaper: _____
- ☐ Search Engine: _____
  Keywords used: _____
- ☐ Other: _____
- ☐ Yelp ☐ Facebook ☐ Pinterest ☐ Instagram
- ☐ Angie's List ☐ Twitter ☐ YouTube ☐ Snap Chat
- ☐ Realself ☐ LinkedIn ☐ Radio

What is the nature of your visit? _____

Emergency Contact

Name: _____ Relationship: ☐ Spouse ☐ Parent/Guardian ☐ Other: _____

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

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Consent to Communicate

Please mark the ways that you would like for us to communicate with you:

Method	Ok to Leave Voicemail	Ok to Leave Message with Another Person	Preferred Contact Method(s)	Best Time to Call*
☐ Call Work Phone	☐Yes ☐No	☐Yes ☐No	☐	
☐ Call Cell Phone	☐Yes ☐No	☐Yes ☐No	☐	
☐ Call Home Phone	☐Yes ☐No	☐Yes ☐No	☐	
☐ Send Email			☐	-
☐ Email Appointment Reminders				
☐ Email Medical and/or Additional Information				
☐ Email Office Specials				
☐ Send Regular Mail			☐	-
Mail to which Address: ☐ Home ☐ Other (please list):				
☐ Send Text Message - if ok, please list cell carrier (e.g., AT&T):			☐	-
☐ Text Appointment Reminders				
☐ Text Office Specials				

*Best Time to Call Examples: morning, afternoon, daytime, evening, emergency only

If it's ok to leave a message with another person, please list them:

Name	DOB	Relationship	OK to Release Results	Any Comments
			☐Yes ☐No	
			☐Yes ☐No	

I have received a copy of the Austin-Weston Center's Notice of Privacy Practices and have been made aware of Patient's Rights and Responsibilities (hard copy available upon request).

The Austin-Weston Center respects and protects our patients privacy and therefore prohibits the use of photography and/or recording devices in and around the building at all times. By signing below I agree to this policy.

Signature: _____ Date: _____