EDWARD J. DOMANSKIS, M.D., INC.
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PLEASE PRINT AND COMPLETE FORM ENTIRELY TODAY'S DATE:_____

PATIENT NAME:_____DATE OF BIRTH: _____ AGE:____
(LAST NAME) (FIRST NAME) (MI)

RESPONSIBLE PARTY:_____RELATIONSHIP:_____

HOME ADDRESS:_____
(STREET) (CITY/STATE) (ZIP)

EMAIL ADDRESS: _____@_____PHONE:_____
By providing my email, and completing/signing this form, I consent to correspondence, which may include Personal Health Information, via email with the offices and personnel of Edward J. Domanskis, M.D., Inc._____(initial)

EMPLOYED BY: _____SOCIAL SEC #: ____-___-_____
(NAME OF FIRM OR CO.) (BUSINESS ADDRESS)
OCCUPATION:_____BUSINESS PHONE:_____

NAME OF SPOUSE: _____
SPOUSE EMPLOYED BY:_____PHONE:_____

RELATIVE/FRIEND IN AREA:_____PHONE:_____

REFERRED BY:_____
(NAME) (RELATIONSHIP)

MEDICAL INSURANCE CARRIER:_____POLICY #:_____

PERMISSION FOR PHOTOGRAPHY

I hereby give my permission to Dr. Domanskis to take necessary clinical photographs of my _____
With the understanding that such photographs are for confidential records, and occasionally such photographs are used for teaching purposes, and that all photographs remain the property of Edward J. Domanskis, M.D., Inc.

_____ _____ _____
Patient / Patient's Legal Representative's Signature Date