



**CLARK**  
Institute for Aesthetics

**Patient Name:** \_\_\_\_\_  
Last Name First Name MI

**Address:** \_\_\_\_\_  
Street Address City State/Zip

**Contact Phone Numbers:** Home: ( ) \_\_\_\_\_ Cell: ( ) \_\_\_\_\_ **Marital Status:** S M W Other

**E-Mail Address:** \_\_\_\_\_ **Date of Birth:** \_\_\_/\_\_\_/\_\_\_ **Age:** \_\_\_\_\_ **Height:** \_\_\_\_\_ **Weight:** \_\_\_\_\_

**\*Would you like to receive emails regarding specials/promotions from our office: YES / NO**

**OCCUPATION:** \_\_\_\_\_ **Employer:** \_\_\_\_\_

**Work Phone Number:** ( ) \_\_\_\_\_ **Address:** \_\_\_\_\_

**NAME OF SPOUSE (Parent if patient is a minor):** \_\_\_\_\_ **Occupation:** \_\_\_\_\_

**Employer:** \_\_\_\_\_ **Work Phone:** ( ) \_\_\_\_\_

**EMERGENCY CONTACT INFORMATION:** **Name:** \_\_\_\_\_ **Phone Number:** ( ) \_\_\_\_\_

**Relationship to you:** Spouse / Friend / Parent / Other: \_\_\_\_\_

**FAMILY PHYSICIAN INFORMATION:** **Physician's Name:** \_\_\_\_\_ **Phone Number:** ( ) \_\_\_\_\_

**Address:** \_\_\_\_\_

**PHARMACY INFORMATION:** **Pharmacy Name:** \_\_\_\_\_ **Phone Number:** ( ) \_\_\_\_\_

**Address:** \_\_\_\_\_

**I heard about Clark Aesthetics through: (Check any and all that apply):**  
 Physician  Friend  Another Patient  Website  Newsletter  Radio  TV  Yellow Pages  
 Publication (which one?) \_\_\_\_\_

**\*Name of Physician/Friend/Patient:** \_\_\_\_\_

**SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

ALL PROFESSIONAL SERVICES RENDERED ARE CHARGED TO THE PATIENT. THE PATIENT IS RESPONSIBLE FOR ALL FEES, REGARDLESS OF INSURANCE COVERAGE. IT IS CUSTOMARY TO PAY FOR SERVICES WHEN RENDERED UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE IN ADVANCE.