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.