EMORY FACIAL CENTER
PATIENT INFORMATION

Today's Date ____

Name (as listed on your driver's license) ________________________________

Address ____

City ____________________ State ________ Zip Code ________________

Home Phone ____________________ Cell Phone ____________________

Birth date ____________________ SS# ____________________

Marital Status ______________ Age ______________ Sex ____________

Employer ____

Work Phone ____________________ Occupation ____________________

Emergency Contact Name ____

Relationship to Patient __________ Emergency Contact Phone Number(s) ____________

Personal Physician ____

Address ____________________ Phone ____________________

How did you hear about Emory Facial Center?

❑ Referring physician name:	Address:
Phone:	
❑ A friend/family member	Name:
❑ Radio/TV	Specify station:
❑ Magazine/Publication	Specify ad:
❑ Emory Facial Center website	
❑ Internet	Source:
❑ Other	

Cancellation policy

Emory Facial Center requires a 48 hour notice of cancellation. Appointments cancelled or rescheduled within 48 hours of your scheduled appointment or missed appointments are subject to a $100.00 fee that will be billed to the patient. We thank you for your understanding and cooperation. __________ (please initial)

Authorization and Assignment of Benefits

I hereby assign and authorize payment directly to The Emory Clinic, Inc of all medical and/or surgical benefits to which I am entitled under any benefit plans. I understand and acknowledge that this assignment of benefits does not relieve me of my financial responsibility for all fees incurred. I acknowledge that the medical information given has been completed by the patient or a representative of the patient.

Patient Signature ____
(If minor, parent or guardian signature)

Date ____________________________