PINK Plastic Surgery

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Patient Intake Form

Patient Information:

Name: _____
Birth Date: _____SSN:_____
Cell Phone:_____Home Phone: _____
Address:_____
City, State, Zip:_____
Email :_____
Emergency Contact: _____
Emergency Contact phone # & relation: _____

Medical Care:

Primary Care Physician: _____
PCP Phone#:_____
Pharmacy Street & City:_____
Pharmacy Phone #:_____
Referring Physician:_____
Referring MD Phone #:_____

_____ (initial) Bills are ONLY sent by email, please provide information.

_____ (initial) Appointment reminders are only done via text. I understand that if I am late for an appointment, I may have to wait. If I am 15min late, I may be rescheduled.

Signature: _____Date:_____

* Patient is Spanish Speaking and this form was translated by Griselda Ramirez