Patient Information Form —— Jonathan Kramer, MD, PLLC

Name:_____ Birthdate:_____Age:_____

Address:_____ Social Security Number:_____

City:_____State:_____Zip_____ Home Phone:_____

E-mail address:_____ Work Phone:_____

*(We ask all patients to supply a drivers license or photo ID for identification in your chart) Cell Phone:_____

Employer:_____ Occupation:_____

Marital Status:_____ Spouse Name:_____

Emergency Contact:_____ Phone:_____

How did you hear about our practice?_____

Specific Reason for visit:_____

Please Circle any additional services you would like to learn about:

FACE	BREAST	BODY	SKIN
Facelift	Breast Augmentation	Liposuction	Botox Cosmetic
Earlobe Repair	Breast Lift	Tummy Tuck	Facial Fillers
Brow Lift	Breast Revision	Mommy Makeover	Facials
Neck Lift	Breast Implant Exchange	Body Lift	Microdermabrasion
Chin Augmentation	Breast Reduction	Arm Lift	Skin Resurfacing
Facial Fat Transfers	Breast Asymmetry	Thigh Lift	Hand Rejuvenation
Upper Eyelids	Male Breast Reduction	Fat Transfer	Hyperpigmentation
Lower Eyelids		CoolSculpting	Skin care
Rhinoplasty		Laser Hair removal	Acne
Kybella			Latisse
			Chemical Peels

Consent for Treatment

I _____, represent to the physicians and staff that I am at least 18 (eighteen) years of age or, if not, am accompanied by a legal guardian. I hereby consent to and authorize examination and treatment by Dr. Kramer and such assistant or staff as may be assigned by him. I also understand that photography is a necessary part of planning and evaluating for cosmetic or other surgical procedures, and authorize the taking of photographs at the direction of Dr. Kramer for education and documentation

I affirm that the above information I have given is correct to the best of my knowledge.

Signature:_____Date:_____

Relationship:(circle one) PATIENT SPOUSE PARENT GUARDIAN

* *Please Complete Back Page*

Insurance Information (Please supply your insurance card so we may make a photocopy for our records.

1.Insurance Company:_____ Policy Holder Name:_____

ID#_____Group #_____ Policy Holder Employer_____

Policy Holder DOB_____

Address:_____ Phone #_____

2. Insurance Company:_____ Policy Holder Name:_____

Policy Holder Employer_____

ID#_____Group #_____Policy Holder DOB_____

Address:_____Phone #_____

To All Insurance Subscribers

We are more than happy to submit claims for "medically necessary" services rendered. We are unable to submit a claim to insurance for any service that is deemed cosmetic by our office. Therefore, you will be held responsible for any cosmetic balance accrued, or any balance for non-covered services. In the event that your insurance company does pay towards services provided by Dr. Kramer, you will be held responsible for any remaining balances. All accounts should be paid in full within 60 days. Co-payments/co-insurance is due at your consultation visit.

I affirm that the above information I have given is correct to the best of my knowledge.

Signature:_____Date:_____

Relationship:(circle one) PATIENT SPOUSE PARENT GUARDIAN