Earl Stephenson, Jr., M.D., D.D.S., F.A.C.S.
Certified, American Board of Plastic Surgery

Patient Form: **AESTHETIC**

Name: ____

Address: ____ Home Phone: _____________

City: _________________________ State: ____ Zip: ______ Cell Phone: ______________

Email Address: ___________________________

Date of Birth: / / Age: ___ Sex: Male __ Female __ SSN: ____________________

Employer: _____________________________________ Work Phone: ________________

Preferred Pharmacy: _____________________________ Pharmacy Phone: _____________

Referred by: ________________________ Reason for appointment: ____________________

Emergency Contact Information

Name: ______________________________ Relationship: __________________________
Phone: __________________

Nearest Relative or friend not living with you: _______________________________________
Phone: ____________

Do We Have Permission to:

Leave a message and/or contact you at home? YES ___ NO ___
Leave a message and/or contact you at work? YES ___ NO ___
Discuss your medical condition with any member of your household? YES ___ NO ___
If YES, whom: ____________________________ Relationship: ____________

I hereby authorize all licensed professionals employed by Signature Plastic Surgery to perform such professional diagnostic, laboratory, medical and surgical procedures as are necessary in their judgement, and to render such care and services as are customary and necessary.

Patient Signature: _______________________________________ **Date**: _____________