Richmond Surgical Arts, Inc.

The Skin Rejuvenation Center

Gregory T. Lynam, M.D., D.D.S.

[PLEASE PRINT AND FILL OUT THE FORM COMPLETELY]

Patient's Name: _____ **Sex:** ☐ **M** ☐ **F**
Last First Middle

Patient's Address: _____
Street & Apt. # City State Zip

Home Phone: _____ **Cell Phone:** _____

Date of Birth: ____/____/____ **Age:** _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Partner ☐ Widowed

Would you like to receive email updates about products, specials, etc.? ☐ Yes ☐ No
Email address: _____

EMERGENCY CONTACT
Person to notify in case of an emergency: _____ **Relationship:** _____

Home Phone: _____ **Cell Phone:** _____ **Work Phone:** _____

EMPLOYMENT INFORMATION
Employer: _____ **Occupation:** _____

Address: _____ **Work Phone:** _____

Spouse's/Partner's Name: _____ **Employer:** _____

Address [if different from above]: _____

Work Phone: _____

What brings you in today? Let us know the primary reason for your visit. _____

_____

_____

_____

IF PATIENT IS A MINOR, PLEASE PROVIDE THE FOLLOWING INFORMATION:

Father's name: _____ **Employer:** _____
Work phone: _____
Mother's name: _____ **Employer:** _____
Work phone: _____

I hereby assign payment to the above physician. I am financially responsible for all charges. I also agree that in the event that my account must be turned over to an attorney for collection that I will be responsible for attorney's fees, court costs, and interest.

_____ _____
Signature Date