

Craig N. Creasman, MD, FACS

PATIENT ENCOUNTER FORM

Last name _____	First name _____	M.I. _____
Street address _____		
City _____	State _____	ZIP _____
Home phone _____	Work phone _____	Cell _____
Email address _____		
<input type="checkbox"/> Yes, I would like to be contacted for in-office promotions (a few times a year) via:		
<input type="checkbox"/> Email <input type="checkbox"/> Mail		
Date of birth _____	Age _____	
Gender (circle one) Male Female	Ethnicity _____	
Employer _____	Occupation _____	
Marital Status _____	Spouse's name _____	

- How did you hear about our office?(circle one): Creasman.com, Internet, Friend, Yellow Pages
- If you were referred by one of our patients, would you be willing to share their name so we can thank him/her? Yes, name _____ I do not wish to share

Drug allergies _____

Personal physician _____

Do you have health insurance? _____ Insurance carrier _____

Emergency contact: Name _____ Number _____

Would you be interested in any of the following? (Check all that apply)

<input type="checkbox"/> Botox	<input type="checkbox"/> Collagen Therapy	<input type="checkbox"/> Restylane/Juvederm	<input type="checkbox"/> Chemical Peels	<input type="checkbox"/> Vein Treatment
<input type="checkbox"/> Skin Care	<input type="checkbox"/> Laser Hair Removal	<input type="checkbox"/> Skin Resurfacing	<input type="checkbox"/> Skin Rejuvenation	

I attest that the information provided above is accurate and true to the best of my knowledge. I understand that I am responsible to pay for services rendered including attorney's fees and costs of collection in the event of default. I further understand that if payment becomes thirty (30) days past due, delinquency charges at the lesser of the annual rate of 15%, or the maximum allowable rate, will be due on delinquent amounts from the date the payment was due.

Signed: _____ Date: _____