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Lexington Plastic Surgery™

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**Theo Gerstle, M.D.**

**PATIENT INFORMATION** (please print) **Date:** _____/_____/_____

• He/Him • She/Her
• They/Them **Ethnicity**: _____

**Patient Name:** _____
Last First M.I.

**Address:** _____
Street City State Zip

**Home phone:(**_____) _____ **Cellular phone:(**_____) _____

**E-mail:** _____

**Sex: M F** **Birthdate:**_____/_____/_____ **Soc. Sec. #:** _____-_____-_____
(REQUIRED) (REQUIRED)

**TREATMENT(S) of INTEREST**:_____

**OCCUPATION**: **Employer:**_____

**Employer Address:** _____

**PHARMACY**

**Name:** _____ **Phone:** _____ **City:** _____

**EMERGENCY CONTACT**: _____
Name Relation Phone

DRUG ALLERGIES? _____ None If yes, please list medication and reaction.

Name of Medication Reaction (i.e. nausea, itching, rash, etc)
1)_____ _____

2)_____ _____

3)_____ _____

OTHER ALLERGIES? _____ None If yes, please check all that apply.

___ Latex ____ Adhesive Tape ____ Contrast Dye ____ Iodine ____ Seafood
___ Metal ____Other, please list _____

Any medications, vitamins, over-the-counter herbal preparations/supplements? ____ None

If yes, please list below

Name of Medication Strength (mg) How many times a day? Reason for taking it

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

Do you have a skincare regimen? Y N (Product)_____

How did you hear about us: _____

## POLICIES AND AUTHORIZATIONS RELATED TO PAYMENT

### Payment Policy

All professional services rendered are charged to the patient and are due and payable at the time of service. Necessary forms will be completed to help expedite insurance carrier payments. However, the patient is responsible for all fees, including deductibles and co-payments, regardless of insurance coverage. Past due accounts greater than thirty (30) days will be subject to an interest fee of 1.5% per month. Past due accounts may also be subject to attorney's fees, collection fees, legal fees, and / or court costs incurred as a result of our attempt to collect the debt. A service fee of $25.00 will be assessed for each returned check.

I understand that I am financially responsible for the payment of any amount not covered by my insurance carrier. A copy of this signature is as valid as the original.

_____ _____

Signature of Patient or Personal Representative Date