Client Information Form

Date: ____/____/____

New River Aesthetics
2617 Sheffield Dr.
Blacksburg VA, 24060

Name: _____
LAST FIRST MIDDLE

Mailing Address: _____ City: _____

Street Address: _____ State: _____ Zip Code: _____

Home Telephone: (_____) _____-_____ Date of Birth: _____/_____/_____
Mobile Telephone: (_____) _____-_____ Social Security #: _____
Work Telephone: (_____) _____-_____

Email Address: _____ ☐ Married ☐ Single
Employer: _____ Gender: Male / Female (circle one)

Emergency Contact Information

Name: _____

Address: _____

Phone #: (_____) _____ - _____

Alt Phone #: (_____) _____ - _____

Relationship: _____

Primary Care Physician: _____
Phone #: (_____) _____ - _____ Last Visit: _____

Preferred Pharmacy: _____
Location:_____ Phone #:(_____) _____ - _____

How did you hear about our Practice? _____
_____

Reason for your visit today: _____
_____

Please Check the Services You Would Like Information About:

	Facial Rejuvenation		Laser Treatments		Vein Treatments
☐	Botox	☐	Hair Removal	☐	Facial Veins / Redness
☐	Restylane / Juvederm / Perlane	☐	Brown Spots / Age Spots	☐	Rosacea
☐	Glycolic Fruit Acids	☐	Scar Revision	☐	
☐	Photo Facial	☐	Post Pregnancy Stretch Marks	☐	
☐	Facials	☐	Fractional Laser Wrinkle Treatment	☐	
☐	Microdermabrasion	☐		☐	

Cancellation Policy: We will see patients by scheduled appointments, and our office staff will make every effort to schedule your appointment at a time that is most convenient for you. If you need to cancel your appointment, please call at least ***24 hours*** in advance of your scheduled time so that we may provide that appointment time to another patient. ***We will confirm your appointment prior to the scheduled date and time. Failure to show for a confirmed appointment will result in a $40.00 no-show fee that is not billable to your insurance. Please refer to the no-show policy.***
I also understand that I am responsible for payment of services not covered by my insurance company and that payment for co-pays and non-covered services are required at the time of service.
I have reviewed a copy of the privacy practices for Daniel Hurd D.O., F.A.O.C.D.

Patient Signature: _____ Date: _____/_____/_____

(If you would like a copy of the Notice of Privacy Practices, please ask the front office personnel.)

Rev. 1/26/15

Authorization for Communication of Medical Information

To our patients:

It is necessary for us to have a written consent in your medical file if you want us to be able to communicate any medical information about yourself to another individual. If you want us to release information to a family member such as a spouse, a parent, a sibling, your child/children, a significant other or any individual; you must indicate the name of that specific person(s).

We will be unable to release any information to anyone other than those indicated on this form.

I _____, hereby give my permission for the office staff of Daniel Hurd D.O., F.A.O.C.D. to release medical information about myself to:

_____

Name of person you are authorizing Relationship

_____

Name of person you are authorizing Relationship

_____

Name of person you are authorizing Relationship

_____

Name of person you are authorizing Relationship

I may cancel this authorization at any time by written notification. If this authorization is not revoked, it will remain in effect indefinitely.

_____

Signature Printed Name Date

If you do not wish to authorize the release of your medical information to any individual, please sign below.

I, _____, decline to have any medical information in regard to myself released to any individual. All medical information will be communicated only to me.

_____

Signature Printed Name Date