Date: _____

Patient's Name _____
First Middle Last

Address: _____
Street and Apt. # City State Zip

Home Phone: _____ Cell Phone: _____ Email: _____

Northern Address: _____
Street and Apt. # City State Zip

Northern Phone: _____

Restrictions for contacting you? ☐ No ☐ Yes Contact Restrictions: _____

Age: _____ Birthdate: _____ SSN: _____

Marital Status: ☐ Married ☐ Single ☐ Widowed ☐ Divorced Gender: ☐ Male ☐ Female

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How did you hear about us? Mark all that apply:

☐ TV ☐ Radio ☐ Magazine ☐ Seminar ☐ Internet ☐ Newspaper ☐ Website ☐ Other: _____

☐ Friend/Relative: _____ ☐ Physician Referral: _____
Name Name

If you were referred by a specific person, may we thank them? ☐ Yes ☐ No

Emergency Contact: _____ Relationship to Patient _____

Home Phone: _____ Work Phone: _____Other Phone: _____

Primary Health Insurance Company: _____

Policy #: _____ Group #: _____ Insurance Phone: _____

Referral Required? ☐ Yes ☐ No
Insured: Name _____ DOB _____ Employer _____

I, the undersigned, authorize payment of medical benefits to Patrick M. Flaharty, M.D., and/or Azul Cosmetic Surgery and Medical Spa, P.A. for any services furnished me. I understand that I am financially responsible for any amount not covered by my contract. I also authorize you to release to my insurance company or their agent, information concerning health care, advice, treatment or supplies provided to me. This information will be used for the purpose of evaluating and administering claims of benefits.

_____ _____
Patient, Parent or Guardian Signature (if child is under 18 years old) Date

AZUL
Cosmetic Surgery and Medical Spa

Date: _____