DENTON D. WEISS, MD, FACS (757) 490-7545

Patient Information

(Please Print Legibly & Fill In All Fields)

Patient's Name _____
First Middle Last

Address: _____
Street & Apt # City State Zip

SS#: _____ Date of Birth: _____ Age: _____ Gender: ❒ Female ❒ Male

Home #: _____ Work #: _____ Ext: _____ Cell #: _____

E-mail: _____ Other Phone/Pager: _____

Any restrictions for contacting you? ❒ Yes ❒ No Contact Restrictions: _____

If you have a telephone answering machine at home, may we leave a message there? ❒ Yes ❒No

Marital Status ❒ Single ❒ Married to: _____ ❒ Other: _____

Emergency Contact _____ Relationship to Patient _____

Home Phone _____ Work Phone _____ Other Phone _____

Patient's Employer _____ Occupation _____

Address _____
Street & Suite # City State Zip

Is it okay to call you at work? ❒ Yes ❒ No

How did you hear about Dr. Weiss' Practice? _____ (Mark all that apply)

❒ TV News ❒ TV Ad ❒ Phone Book ❒ Magazine ❒ Newsletter ❒ Seminar ❒ Salon ❒ Web

❒ Friend/Relative: ❒ Doctor: ❒ Other:

I understand that office visit charges are payable on the day service is rendered. I authorize Dr. Denton D. Weiss to bill my insurance company for medically necessary services. Regardless of insurance coverage, I am responsible for all bills being paid in a timely manner. I understand that my contract is between Dr. Denton D. Weiss and myself.

Patient Signature: **Date**