Radiance
CENTER FOR FACIAL REJUVENATION

INTAKE FORM

Kent E. Gardner, M.D., F.A.C.S
Board Certified in Facial Plastic Surgery

Patient Name:

Last _____ First _____ Middle Initial _____

Address: (mailing) _____

Cell Phone # _____ Home Phone # _____ Work # _____

SS# _____ Marital Status _____ Age _____ Gender _____

Occupation _____ Employer _____

Spouse/Guardian Name _____

Emergency Contact _____ Phone # _____

Primary Care Doctor _____ Last Time Seen _____

How did you hear about our office? _____

Email _____ Consent to use email to contact you: (check) ☐ Yes ☐ No

Assignment and Release:
I understand that I am financially responsible to the physician for all charges relative to my visits and/or treatment. I certify that all information given on this patient information sheet is complete and correct to the best of my knowledge and that a photocopy or digital facsimile of this assignment is considered as valid as the original.

General Permit for Care:
I hereby given permission to Dr. Kent E. Gardner to render treatment as he sees fit upon myself, my child or the person of whom I have guardianship. I agree he can call any consultant, anesthesiologist or laboratory personnel as he deems advisable in the care of my treatment and case. I also agree to be responsible for the charges of any hospitals, surgical centers or medical facilities that may be incurred. I am advised that although good results are expected, they cannot be guaranteed, nor is there any guarantee against untoward results.

Cosmetic Patients:
Cosmetic patients are required to pay a consultation fee of $50.00 payable at first appointment. A $500.00 deposit is required to schedule any surgery date. This deposit is non-refundable if surgery is cancelled less than seven days **BEFORE** surgery.

I agree and give my consent for the above policy:

Signature of Patient/Guardian _____ Date: _____