GARDNER
FACIAL PLASTIC SURGERY

Kent E. Gardner, M.D. F.A.C.S

Double Board Certified in Facial Plastic Surgery and Otolaryngology

Patient Name: _____
Last First Initial

Address: (mailing) _____

Home Phone # _____ Work # _____

SS# _____ Marital Status: _____ Birthdate: _____Gender: _____

Occupation: _____ Employer: _____

Spouse/Guardian Name: _____

Emergency Contact: _____ Phone number# _____

Primary Care Doctor: _____Last time seen: _____

How did you hear about our office?

Email: Consent to use email to contact you: (circle) Y or N

*Email notifications may be sent for appointment reminders, surgery instructions, patient education and in office specials and discounts.

Assignment and Release:
I understand 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 for whom I have guardianship of. I agree he can call any consultant, anesthesiologist, 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 $100 payable at the first appointment. The $100 consultation fee will be applied towards the cosmetic procedures and/or surgical balance due. A $500.00 deposit is required to schedule any surgery date. This deposit is non-refundable if surgery is cancelled less then seven days **BEFORE** surgery.

I agree and give my consent for the above policy:

Signature of Patient/Guardian_____ Date: _____

Gardner Facial Plastic Surgery
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