ETHAN PHILPOTT, M.D.

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PATIENT INFORMATION

Date: ___________________________

Patient's Name: ____ **Male:** ☐ **Female:** ☐

Address: ____

City: ______________________ **State:** __________ **Zip:** ______________________

E-mail Address: ____

Social Security Number: XXX-XX-_______ **Date of Birth: :** ______________________

Occupation: ______________________ **What is best way to reach you?** ☐ **text** ☐ **phone** ☐ **e-mail**

Home Phone: __________________ **Work Phone:** __________________ **Cell Phone:** __________________

Parent/Spouse's Name: ______________________________ **Phone:** __________________

Primary Physician: ______________________________ **Phone:** __________________

Pharmacy Name: ______________________________ **Telephone Number:** __________________

Pharmacy Cross Streets: ____

Emergency Contact: __________________ **Relationship:** __________________ **Phone:** __________________

How did you hear about us? Friend/Relative: ☐ **Employee:** ☐ **Internet:** ☐ **Media (Newspaper, Advertisement):** ☐

If you were referred by a friend, relative, or employee, please tell us their name: ______________________

Authorization to Treat

I hereby give my permission to Body Sculpting Center and BodyNew MedSpa licensed medical professionals to administer treatment and to perform procedures as may be deemed necessary in the diagnosis and/or treatment of myself or my dependents.

I understand that I will be charged a fee for missing or canceling an appointment if I do not notify the office at least **48 hours** prior to the appointment.

Patient's Signature: ____ Date Signed :__________________

(Parent if Patient is a Minor)

Received By:__________________