Laser and Liposuction Center

Robert W Poe, MD
Cynthia N Frazier, MD

WELCOME

NAME____
first middle last

DOB________________Mobile_______________________Home_______________________________

Email____

Street
address____

City_________________State______Zip________ Ht/Wt________/__________

Primary Care Physician________________ Preferred Pharmacy_________________________________

Current smoker: Y / N (packs per day) ______Do you have any electronic or metallic implants? _______

Do you have any history of abnormal or prolonged bleeding? ___________________________________

Allergies____

Current Medications

MEDICATION	DOSAGE	FREQUENCY

Past Medical and Surgical History

DATE	

Family History (blood relatives)

CONDITION	RELATIONSHIP

Emergency Contact______________________________________Phone#__________________________

Appointment Reminder Authorization

Please indicate below how you would like to be reminded of your upcoming appointments:

Please circle your selections   EMAIL   TEXT MESSAGE   VOICE MESSAGE

Our office often needs to obtain records from other treating physicians, hospitals, etc, in order to provide optimal medical care and expedite transfer of information. Please sign this form in the space below to allow us to obtain your medical information if needed.

CONSENT FOR RELEASE OF INFORMATION

Patient's Full Name: ____

Patient's Date of Birth: ____

MY SPECIFIED MEDICAL INFORMATION MAY BE RELEASED TO:

ROBERT W. POE, MD
CYNTHIA N. FRAZIER, MD
LASER AND LIPOSUCTION CENTER
915 State Hwy 248 Suite B.
Branson, MO 65616
Phone# (910) 477-6290
Fax# 910-457-9116

This Data Shall Include: ____

____ Date: _______________
(Signature of patient or responsible party, full name)

Notice of Privacy Practices Receipt

I acknowledge that I was provided with the notice of privacy practices of the medical practice named above.

Print Name of Patient: ____

Signature of Patient: ____

Today's Date: _________________________ Patient's Date of Birth: ________________________

For Personal Representative of the Patient (if applicable)
Print Name of Personal Representative: ____
Personal Representatives Relationship to Patient: _____________________________________
Signature of Personal Representative: ____
Today's Date: ____________________