

Bayview Plastic Surgery

300 East Medical Center Boulevard, Webster, Texas 77598 ~ 281-286-1000
www.donnarichmd.com

Today's Date: _____

About the Patient:

Last Name: _____ First Name: _____ MI: _____ Sex: M or F

Social Security No.: _____ Birth date: _____ Age: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____ Home Phone: () _____

Driver's License No.: _____ Marital Status: _____ Work Phone: () _____

E-mail Address: _____ Cell Phone: () _____

Employer: _____ Occupation: _____

Work Address: _____ City/State: _____ Zip: _____

Emergency Contact Name: _____ Phone: () _____

Relationship: _____ Address: _____

Detailed reason for your visit today: _____

Referred by: _____

We use the automated system, Smile Reminder, to confirm patient appointments. Please tell us how you do **NOT** wish to be contacted: Email Text to Cell Both

Opting to be contacted by Smile Reminder will also allow us to send you our Newsletter and specials/event notices.

Bayview Plastic Surgery may contact you at any phone numbers you provide to us, by email and by mail. If you wish to opt out of any point of contact, please check them below. I do **NOT wish to be contacted at:**

Home telephone Work telephone Written communication Cell phone Email

To whom may we give your medical information? _____
