ART QUINTANILLA, MD

BOARD

CERTIFIED PHYSICIAN

# DESERT MEDICAL REJUVENATION

## PATIENT INFORMATION

Title: ( ) Dr. ( ) Mr. ( ) Mrs. ( ) Ms. ( ) Miss.

Legal Name: ________________________________________, ____________________________________________( )Jr. ( ) Sr.

*LAST NAME*

*FIRST NAME*

Date of Birth: ____________/____________/_______________ Sex: ( ) Male ( ) Female

Race: ______________________________________________ Preferred Language:__________________________

## CONTACT INFORMATION

Mailing address:

______________________________________________________________________________________________

*Street #* *Street Name*

*Apt/Unit*

______________________________________________________________________________________________

*City* *State*

*Zip Code*

Home #: ____________________________ Work #:___________________________ Mobile #:__________________________

May we email you appointment reminders, newsletters and specials? If so, please provide your email:

Email address:

______________________________________________________________________________________________

Spouse Name: ___________________________ Phone #:______________________ Spouse/s Date of Birth______/______/______

Emergency Contact: _______________________________ Phone #: _______________________ Relation: ___________________

## PARENT OR RESPONSIBLE PARTY (IF DIFFERENT FROM PATIENT)

Name: _____________________________________________________ Date of Birth: ______/______/______ Sex: ( ) M ( ) F

Address:

______________________________________________________________________________________________

Home #: _____________________________ Work #:___________________________ Mobile #:___________________________

## REFERRAL SOURCE

How did you hear about our practice? ( ) Physician: ____________________________ ( ) Patient:_____________________________

( ) Webpage: ________________________ ( ) Commercial ( ) Newspaper ( ) Billboard ( ) Other:__________________________

## PATIENT PRIVACY

Do we have your permission to discuss your medical condition or allow any member of your household to schedule appointments for you? If yes, whom: ___________________________________________________
Relationship:________________________________

Do we have your permission to:

Leave a message on your answering machine at home? ( ) YES ( ) NO

Leave a message at your place of employment? ( ) YES ( ) NO

Patient Signature:___________________________________________________________ Date: _________________________________