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: _____