WestlakePlasticSurgery™
DR. ROBERT CARIDI

Patient Registration Form

Name: _____
(first) (middle) (last)

Address: _____
(street)

_____
(city) (state) (zip)

Home Phone: _____ Cell Phone: _____

Work Phone: _____ Marital Status: _____

Occupation: _____

Birthdate: _____ Age: _____ Gender: ☐ M ☐ F

Email: _____

Emergency Contact: _____
(first) (last)

Relation to Patient: _____

Home Phone: _____ Cell Phone: _____

Work Phone: _____ Other Phone: _____

How did you hear about us?

☐ WestlakePlasticSurgery.com ☐ Austin Gynecomastia Center ☐ Google ☐ Yelp

☐ Facebook ☐ You Tube ☐ Other Search engine (Which one?)_____

☐ Print ad (Which one)? _____ Dr. or Patient referral? (Who?)_____

Acknowledgement of Review of *Notice of Privacy Practices*

I have reviewed Westlake Plastic Surgery's *Notice of Privacy Practices*, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document at any time.

_____ _____
Signature of Patient or Personal Representative Date

_____
Printed Name of Patient or Personal Representative

_____
Description of Personal Representative's Authority / Relationship to Patient