BLACKLEDGE FACE CENTER

F. Adair Blackledge, M.D.

New / Updated Patient Information

Name _____ Soc. Sec. No. _____

Address _____ City _____ State _____ Zip _____

Home phone no. _____ Cell phone no. _____ Email _____

Employer _____ Occupation _____ Work phone _____

Birth date _____ Single / Married / Widow(er) Sex M / F

Spouse's name _____ Spouse's employer _____

Referral source _____ Pharmacy:_____ Pharm Phone #_____

Minor or Student Information

Mother's name _____ Birth date _____ Home phone _____

Address _____ City _____ State _____ Zip _____

Father's name _____ Birth date _____ Home phone _____

Address _____ City _____ State _____ Zip _____

Emergency Contact

Name _____ Relationship to patient _____

Home phone _____ Work phone _____

Surgical History: Describe any procedures that you may have had and the approximate dates.

_____

Medication Allergies: List any medications and other allergies

_____

Medications: List medications taken routinely

_____

Pharmacy Name/Location: _____ **Number:** _____

From time to time, our staff may contact you to remind you of upcoming appointments or check on your progress. Please initial in the appropriate blank.

_____ I give Blackledge Face Center permission to call or leave messages for me at the above listed phone numbers.

_____ I **do not** give Blackledge Face Center permission to call me.

I hereby certify that I accept full responsibility for all charges for service ordered by me personally and by physicians attending me and agree to pay all charges due at time of service.

I also acknowledge that I have been presented with a copy of this provider's Notice of Privacy Policies as required by federal and state law.

Signature _____ **Date** _____