plastic Surgery
OF VIRGINIA BEACH
Dr. Kevin Bounds

PATIENT INFORMATION – PLEASE PRINT OR WRITE LEGIBLY

PATIENT FIRST AND LAST NAME	MARTIAL STATUS S M DIV WID	AGE	DATE OF BIRTH	SOCIAL SECURITY NUMBER

STREET ADDRESS – [ ] PERMANENT [ ] TEMPORARY	CITY, STATE	ZIP CODE

EMAIL	HOME PHONE NUMBER	CELL PHONE NUMBER

WHO REFERRED YOU TO THIS PRACTICE?	REASON FOR TODAY'S VISIT

PATIENT'S EMPLOYER	OCCUPATION – Indicate if student	HOW LONG?	WORK PHONE NUMBER ( )

EMPLOYER'S STREET ADDRESS	CITY, STATE	ZIP CODE

IN CASE OF EMERGENCY, CONTACT	PHONE NUMBER ( )	RELATIONSHIP

SPOUSE'S NAME/SIGNIFICANT OTHER	SOCIAL SECURITY NUMBER

SPOUSE'S/SIGNIFICANT EMPLOYER	OCCUPATION – Indicate if student	HOW LONG?	WORK PHONE NUMBER ( )

EMPLOYER'S STREET ADDRESS	CITY, STATE	ZIP CODE

I AM INTERESTED IN – CHECK ALL THAT APPLY

BOTOX	FACELIFT	BREAST AUGMENTATION
FILLERS	Z-PLASTY (NECK)	BREAST LIFT
GLYCOLIC PEELS	EYELID SURGERY	BREAST REDUCTION
MICRODERMABRASION	TUMMY TUCK	IMPLANT EXCHANGE
SKINCARE PRODUCT	LIPOSUCTION (LIST AREAS)	AREOLA/NIPPLE SURGERY
LATISSE	LABIAPLASTY	SKIN REMOVAL

I CONSENT to be photographed before, during and after my treatment.
I ACCEPT financial responsibility for charges accumulated and give my permission for this office to release information to my insurance company for filing purposes.
I UNDERSTAND there will be a 60-day grace period as a courtesy to me during which Dr. Bounds' office will wait for my insurance to make payment on my account. Co-pay and deductibles are due before surgery from me according to my insurance policy. If no payment is received from my insurance company, payment will be due directly from me. In the event I default on payment of this account, I agree to pay reasonable attorney fees in the amount of 25% of my balance at the time of collection as well as all collection costs. I authorize payment of medical benefits directly to Kevin B. Bounds, M.D.

SIGNATURE OF PATIENT OR RESPONSIBLE PARTY DATE