Our Secret Medical Spa & Treatment Center
Michele M Zormeier MD, Cosmetic Surgeon

PATIENT INFORMATION

Name: (last) ______________________________ (first) _______________________ (MI) ___

Address: _________________________________ City: _________________ Zip: _________

Home Telephone: (____) __________________ Cell Phone: (____) __________________

Email address: _________________________________ (promotional offers sent via email)

Driver's License No: __________________________ Birth date: ___/___/_____ Age: _______

Occupation: _________________________ Employer Name: ___________________________

Work Address: ________________________________ City: ________________ Zip: _______

Work Telephone: (____) __________________

ADDITIONAL INFORMATION

Spouse Name: ______________________________

Spouse Employer: _______________________ Employer Phone: (____) _________________

Name of relative not living with you: ____

Relation: ____________________________________ Phone: (_____) ____________________

Address of Relative: _____________________________ City: ________________ Zip: _______

Best time to call you: ____

TREATMENTS YOU ARE INTERESTED IN DISCUSSING WITH THE DOCTOR:

____

____

Referred by: ____

To ensure patient financial confidentiality, please discuss all financial arrangements with the patient coordinator.

I understand that I am personally responsible for all charges. I understand that the charges I am responsible for are to be paid in full at the time of service. Should collection proceedings become necessary, I understand that I will be responsible for attorney fees, court costs, and collection costs.

Signature: ____ Date: ________________