DR. ROBERT PETERSON

Patient Registration (Cosmetic)

Please fill in all blanks

Marital Status: **Single** **Divorced** **Married** **Widowed**

Mr. **Mrs.** **Ms.** **Miss** **Dr.** Patient's Name _____

Address _____ Email _____

City _____ State _____ Zip _____

Home _____ Work _____ Cell _____

Primary Care Dr. _____ Office Number _____

Social Security # _____ Date of Birth _____

Patient's Employer _____

How did you hear about us?

Friend/Family _____ Internet Insurance Magazine _____

Doctor _____ Existing Patient _____ Other _____

Spouce Information:

Spouse _____ Spouse Contact _____

Spouse DOB _____ Spouse SSN _____

Spouse Employer _____ Work _____

Photographic Consent

The following is my consent for Dr. Peterson or a staff representative to photograph me for the following purposes. Using respectful and discretionary measures, the photographs may be viewed by medical health care professionals, as well as nonmedical individuals.

____ Patient's file Photographs are required for the patient's file and will be utilized for comparative review during the course of treatment.

____ Office reference These photographs may be used for educational purposes.

____ Internet The discreet use of photographs may be used exclusively on Dr. Peterson's educational website.

By signing, I am granting Dr Peterson permission to use my photographs as checked above.

SIGNATURE _____ DATE _____