DAVID L. RASMUSSEN, M.D., P.A.

Arlington Cosmetic Surgery Center

1017 W. Randol Mill Road • Arlington, Texas 76012 • (817) 469-1163

PERMISSION FOR PHOTOGRAPHY

I hereby give permission to take necessary clinical photographs of (name) _____ with the understanding that such photographs are for confidential, clinical record purposes, and that all photographs remain the property of the doctor.

Occasionally such photographs are used for teaching purposes and for ethical surgical publications for the advancement of surgical knowledge. I will / will not permit the use of these photographs for such ethical professional purposes.

Patient's / Parents' signature _____

Date _____

PATIENT INFORMATION

Patient: Date of Birth: _____ Age: _____

_____ Social Security # _____
First Middle Last (Parent's if patient is a minor)

Residence
Address: _____ Home Phone # _____
Street Apt. #

_____ Work Phone # _____
City State Zip

Cell # _____ Email _____ Fax # _____

Employer: _____ Occupation: _____

Business
Address: _____
Street City State Zip

Name of
Spouse / Parent: _____ Business Phone # _____
(Circle one)

Employer Of Above: _____ Occupation: _____

Business Address
Of Above: _____
Street City State Zip

If Patient Is A Minor, Who Is Legally Responsible? _____

Contact Person In Case Of an Emergency: _____ _____
Name Relationship

Home Phone _____ Work Phone_____ Cell/Email _____

How Were You Referred To Our Office? _____

Reason for seeing the Doctor? _____

Are there any other procedures you are interested in? _____

All charges are due at the time of service. If surgery is indicated, the patient is responsible for furnishing payment 2 weeks prior to surgery.

Date: _____ Signature: _____