

FACIAL REJUVENATION LLC
DR. JULIA K. TERZIS, M.D., Ph.D., FACS, FRCS(C)
330 West Brambleton Ave., Suite 1
Norfolk, VA 23510

PATIENT INFORMATION:

Patient: _____ Date: _____

Street Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Sex: M F Birth Date: _____ Age: _____ Social Security Number: _____

Marital Status: Single Married Divorced Separated Widowed

E-Mail Address: _____ Occupation: _____

Employer: _____ Address: _____

RESPONSIBLE PARTY / BILLING INFORMATION: (If different from self)

Name: _____ Social Security Number: _____

Street Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

EMERGENCY CONTACT INFORMATION:

Name: _____ Relationship to Patient: _____ Phone: _____

Patient's Primary Care Physician: _____ Phone: _____

HOW DID YOU FIRST LEARN ABOUT DR. TERZIS?

- Internet Phone Book Newspaper Magazine
 Family/Friend: _____ Other: _____
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I WANT TO TALK TO DR. TERZIS ABOUT: (Please check all that apply)

- Face Lift Eye Lid Surgery Forehead/Brow Lift Neck Lift Chin Surgery Facial Implants
 Nose Surgery Lip Augmentation BOTOX® Restylane® Other: _____
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I hereby affirm the correctness of the information by me, and do authorize treatment of the above named patient. I waive any and all rights, present and future, without exception, with regard to images, be they still, real, or representative, as requested for personal, financial, insurance, and/or legal reasons. I understand these images do not constitute part of any medical record. There are no medical reports or narrative commentary associated with them. There is no exception. In addition, I agree to have a credit report done. This is required for ALL patient/responsible party who wish to schedule surgery, understanding that these policies do not reflect my individual credit worthiness, or willingness to pay my charges for professional services.

Patient/Responsible Party Signature: _____ Date: _____