Client Information Form Date: ____/____/____		New River Aesthetics 2617 Sheffield Dr. Blacksburg VA, 24060

Name: ____
LAST FIRST MIDDLE

Mailing Address: ______________________ City: ______________

Street Address: ______________________ State: _______ Zip Code: ________

Home Telephone: (______) ________-________ Date of Birth: _____/_____/_____
Mobile Telephone: (______) ________-________ Social Security #: ______________
Work Telephone: (______) ________-________

☐ Married ☐ Single

Email Address: ______________________
Employer: ______________________ Gender: Male / Female (circle one)

Emergency Contact Information

Name: ______________________

Address: ______________________

Phone #: (_____) _____ - ________

Alt Phone #: (_____) _____ - ________

Relationship: ______________________

Primary Care Physician: ______________________
Phone #: (_____) _____ - ______ Last Visit: __________

Preferred Pharmacy: ______________________
Location:__________ Phone #:(_____) _____ - ______

How did you hear about our Practice? ______________________

Reason for your visit today: ______________________

Please Check the Services You Would Like Information About:

	Facial Rejuvenation		Laser Treatments		Vein Treatments
	Botox		Hair Removal		Facial Veins / Redness
	Restylane / Juvederm / Perlane		Brown Spots / Age Spots		Rosacea
	Glycolic Fruit Acids		Scar Revision		
	Photo Facial		Post Pregnancy Stretch Marks		
	Facials		Fractional Laser Wrinkle Treatment		
	Microdermabrasion				

Cancellation Policy: We will see patients by scheduled appointments, and our office staff will make every effort to schedule your appointment at a time that is most convenient for you. If you need to cancel your appointment, please call at least ***24 hours*** in advance of your scheduled time so that we may provide that appointment time to another patient. ***We will confirm your appointment prior to the scheduled date and time. Failure to show for a confirmed appointment will result in a $40.00 no-show fee that is not billable to your insurance. Please refer to the no-show policy.***
I also understand that I am responsible for payment of services not covered by my insurance company and that payment for co-pays and non-covered services are required at the time of service.
I have reviewed a copy of the privacy practices for Daniel Hurd D.O., F.A.O.C.D.

Patient Signature: ______________________________ Date: _____/_____/_____

(If you would like a copy of the Notice of Privacy Practices, please ask the front office personnel.)

Rev. 1/26/15