# The Plastic Surgery Experts

Mark Mandell-Brown, M.D.

Date: _____

Patient's Name: _____

Street Address: _____
(If College student please provide permanent address)

City: _____ State: _____ Zip: _____

Home Phone: (  ) _____ Work #_____

Cell# _____ OK to Text Appointment Information: **yes** **no**

Date of Birth: _____ Age: _____ Sex: **M** **F**

E-Mail Address: _____OK to E-mail**:** **yes** **no**

Marital Status: _____ Race: _____

Patient's Employer: _____ Occupation: _____

Emergency Contact: _____ Phone # _____

Family Doctor _____ Phone # _____

Referral Source _____

**Please read and sign below**:
I certify that the information given by me is correct. I understand that I am financially responsible for the charges for any services rendered to me by my physician(s). I also understand that I am responsible for payment for services rendered by Dr. Mark Mandell-Brown and Staff at the time of service.

After 2 years, credit balances under $250.00 will not be returned without a written request. All service packages purchased in advance must be used within 2 years of purchase date or remainder is forfeited.

I have seen the lobby posting of this physicians practice **PRIVACY POLICY, PATIENT RIGHTS AND RESPONSIBILITIES.** Furthermore, upon my request, I will be given a copy of the Patient Rights and Responsibilities. **The Mandell-Brown Plastic Surgery Center does not honor Advance Directives because only elective procedures are performed at this facility.**

Signature: _____ Date: _____

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Cincinnati, Ohio 45242
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