Nicholas E. Sieveking, M.D. · Jeffrey R. Claiborne, M.D.
204 23rd Avenue N. Nashville, TN 37203

PATIENT INFORMATION

NAME ____ **AGE**__________ **BIRTHDATE** ______________
last first middle initial
SOCIAL SECURITY # __________-__________-__________ (must have for surgery) **SEX** (circle one) MALE FEMALE

ADDRESS ____
street apt number

____
city state zip code
MARITUAL STATUS ______________________________ **SPOUSE'S NAME** ______________________________

HOME PHONE ______________________________ **CELL PHONE**______________________________

E-MAIL ____

REQUEST FOR CONFIDENTAL COMMUNICATIONS VIA E-MAIL/MAIL/PHONE CALLS
May we leave a personal message on the number(s) provided? Y or N May we contact you through email regarding personal medical information/communicating with Staff? Y or N May we leave a message with another person answering the number(s) provided? Y or N May we send text messages to contact you? Y or N

ALLERGY TO MEDICATIONS ____
FAMILY PHYSICIAN ____
PATIENT PHARMACY ______________________________**PHARMACY NUMBER** ____________________
EMERGENCY CONTACT ______________________________ **PHONE NUMBER** ____________________
EMPLOYER ______________________________WORK **PHONE**____________________

RESPONSIBLE PARTY INFORMATION (MINOR OR CAREGIVERS ONLY)

RESPONSIBLE PARTY NAME______________________________ **RELATIONSHIP TO PATIENT**____________
PRIMARY PHONE # ______________________________
ADDRESS__________________________________ street
apt number

____
city state zip code

REASON FOR CONSULTATION (List All) ____
HOW DID YOU HEAR ABOUT OUR OFFICE? ____
REFERRED BY ____

CANCELLATION POLICY

We kindly ask for a minimum of 24-hours' notice to cancel or reschedule any appointment. Most in office procedures with Dr. Claiborne/Dr. Sieveking/Laser appointments are subject to a $500 deposit. Any appointment cancelled with less than the required 24-hours' notice or No Showed, will result in the loss of deposit or loss of the scheduled treatment from your membership package (if applicable). Please sign that you have read, understand and agree to this policy.

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Patient/Guardian Signature____ Date_________________________________

STATEMENT OF FINACIAL RESPONSIBILITY

The service(s) you have elected to participate in implies a financial responsibility on your part. The responsibility obligates you to ensure payment in full of our fees. All cosmetic fees are due PRIOR to surgery or at the time cosmetic laser and skin care services are rendered. Care Credit options are available. Payments may be by cash, check, or credit card. Deposits due 2 weeks from scheduling a surgery date, which is 20% of the physician's fee and if the patient does not give a 14-day notice of cancellation they will forfeit the deposit amount and all other balances will be refunded.

Patient/Guardian Signature____ Date_________________________________