



PLASTIC SURGERY
IDAHO FALLS & JACKSON HOLE

1855 Madison Ave.
Idaho Falls, ID
(208) 881-5351
www.DrMarkFreeman.com

Patient Information Form

Patient Name: _____ Nickname: _____ DOB: _____ Gender: _____

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

E-mail address: _____ Social Security Number: _____

Preferred Contact Method(s)	Method	Ok to Leave Voicemail	Ok to Leave Message with Another Person
<input type="checkbox"/>	Cell Phone:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Cell Phone Carrier (e.g. AT&T, Verizon, etc.):		
<input type="checkbox"/>	Home Phone:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/>	Work Phone:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

We offer electronic communication for appointment reminders, office news, and special promotions to the e-mail address and cell phone on file. Please indicate your consent for us to communicate with you electronically.

Yes, Text me Appointment Reminders and Office Promotions

Yes, E-mail me Appointment Reminders , Medical Information and Office Promotions

Preferences

Which pharmacy do you use? _____ Pharmacy Phone #: _____

Who is your primary care physician? _____ PCP Phone: _____

Emergency Contact

Name: _____ Relationship: Spouse Parent/Guardian Other: _____

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