

WestLake



Dr. Robert Caridi  
PLASTIC SURGERY

**PATIENT REGISTRATION FORM**

Name: \_\_\_\_\_  
(first) (middle) (last)

Address: \_\_\_\_\_  
(street)  
\_\_\_\_\_  
(city) (state) (zip)

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Work Phone: \_\_\_\_\_ Marital Status: \_\_\_\_\_

Occupation: \_\_\_\_\_

Birthdate: \_\_\_\_\_ Age: \_\_\_\_\_ Gender:  M  F

Email: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_  
(first) (last)  
Relation to Patient: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_  
Work Phone: \_\_\_\_\_ Other Phone: \_\_\_\_\_

How did you hear about us?

- Patient referral
- Physician referral
- Radio
- Online Radio
- Print
- Our Website
- Search Engine (Google, Yahoo, etc.)
- Word of mouth
- Other

Referred by: \_\_\_\_\_

**ACKNOWLEDGEMENT OF REVIEW OF NOTICE OF PRIVACY PRACTICES**

I have reviewed Westlake Plastic Surgery's *Notice of Privacy Practices*, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document at any time.

\_\_\_\_\_  
Signature of Patient or Personal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name of Patient or Personal Representative

\_\_\_\_\_  
Description of Personal Representative's Authority / Relationship to Patient