

PAUL VITENAS JR., M.D.

Patient Information as of _____ (enter today's date)
(Please Print Legibly & Fill In or Correct All Fields)

Patient's Name

First

Middle

Last

Address

Street & Apt #

City

State

Zip

Home Phone

Cell Phone

Other Phone

Any restrictions for contacting you?

No

Yes

E-mail

Contact Restrictions:

Age

Birthdate

/

/

SS#

-

-

Gender

Female

Male

Marital Status

Single

Married to:

Other:

Patient's Employer

Occupation

Work Phone

Ext:

Is it okay to call you at work?

Yes

No

Address

Street & Suite #

City

State

Zip

Whom may we thank for referring you?

Emergency Contact

(Not in your household)

Relationship to Patient

Home Phone

Work Phone

Other Phone

Patient Photographic Authorization and Release

I, _____, authorize, Dr. Vitenas and/or his representative(s), to take photographs, slides or videotapes of me or parts of my body for the following procedure(s) and for medical purposes to be used for my care, medical presentations and/or articles.

Such photographs, slides or videotapes may be published by Dr. Vitenas in any print, visual, or electronic media including, but not limited to, medical journals and textbooks, scientific presentations and teaching courses, and Internet web sites, for the purpose of informing the medical profession or the general public about plastic surgery methods.

I will not be identified by name in any of the media described above; however, I also understand that in some circumstances the photographs, slides, or videotapes may display features that identify me.

I have the right to revoke this authorization in writing at any time and, if I decide to do so, I must present my written revocation to the practice manager at 11914 Astoria Blvd, Suite 470 Houston, TX 77089. A revocation shall not affect any release of information made prior to revocation in reliance upon this Authorization.

I may refuse to sign this authorization without such refusal affecting the medical treatment I receive from Dr. Vitenas.

I release and discharge Dr. Vitenas from all liability, including liability for negligence, which in any way arises out of:

any and all rights that I may have or may have had in the photographs, slides or videotapes of me that I have authorized to be used and disclosed in this Authorization; and

any claim that I may have or may have had relating to such use and disclosure of those photographs, slides or videotapes of me, including any claim for payment in connection with any distribution or publication of them in any medium.

This Authorization is made as a voluntary contribution in the interest of public education and certifies that I have read this Authorization and Release carefully and fully understand its terms.

If I have questions about the use or disclosure of my photographs, slides, or videotapes, I can contact the practice manager at 281-484-0088.

Signature: _____

Date: _____

Witness: _____

Your electronic signature on this form is your legal signature signifying that you understand what has been presented to/discussed with you and you have given your informed consent to the policies.