

Today's Date
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New	
Update	

**West Houston Plastic Surgery Clinic, P.A.**  
**ALFONSO BARRERA, M.D., F.A.C.S.**  
**Diplomate of the American Board of Plastic Surgery**  
**Clinical Assistant Professor of Plastic Surgery**  
**Baylor College of Medicine**

**Plastic & Reconstructive Surgery and Hair Transplantation Surgery**

**Please print all information clearly**

Patient's Name – Last		First		Middle Initial	
Email Address:					
Marital Status	Social Security #	Age	Date of Birth	Drivers License - State	
Patient's Address		Apt #	City	State	Zip Code
Telephone Number (    )	Mobile Number (    )		Other / Pager Number (    )		
Patient's Occupation	Patient's Employer				
Employer's Address		City - State	Zip Code	Work Number (    )	
Name of Spouse	Employer			Work Number	
Next of Kin ( Other than Spouse)		Relationship	Telephone Number		

**Person Responsible for Bill**

Guarantor's Name – Last		First		Middle Initial	
Guarantor's Address		City - State		Zip Code	
Guarantor's Employer			Telephone Number		
Address		City - State		Zip Code	

I hereby agree to pay my account as services are provided. If for any reason there is a balance owing on my account, I agree to pay promptly upon receipt of the monthly statement. I acknowledge and understand that I am responsible for all of the charges for all of the services rendered to me or any member of my family.

Signature \_\_\_\_\_ Date \_\_\_\_\_