



**JAIME R. GARZA M.D.**  
TEXAS PLASTIC SURGERY

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Home Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Telephone: (\_\_\_\_) \_\_\_\_\_ Mobile: (\_\_\_\_) \_\_\_\_\_ Birthdate: \_\_\_\_\_ Age: \_\_\_\_\_

**Email Address:** \_\_\_\_\_

May we send information here? Yes\_\_\_ No\_\_\_

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

Employer: \_\_\_\_\_

Employer's Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Work Phone: (\_\_\_\_) \_\_\_\_\_

***Complete this section only if someone other than the patient is financially responsible.***

Name of Spouse: \_\_\_\_\_ Birthdate: \_\_\_\_\_

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

Employer: \_\_\_\_\_

Employer's Address: \_\_\_\_\_

Employer's Telephone: \_\_\_\_\_

In case of emergency, contact: \_\_\_\_\_

Home phone: (\_\_\_\_) \_\_\_\_\_ Work phone: (\_\_\_\_) \_\_\_\_\_

Who may we thank for referring you? \_\_\_\_\_