



Beauty laser & wellness center
Monica Bonakdar, MD

REGISTRATION FORM

CLIENT INFORMATION

DATE: _____

NAME (LAST, FIRST, MIDDLE): _____

BIRTHDATE: ____/____/____ AGE: _____ SEX: MALE FEMALE

STREET ADDRESS: (PO BOX NOT ACCEPTED): _____

CITY: _____ STATE: _____ ZIP CODE: _____

Please indicate the phone numbers you'd like us to use FIRST & SECOND to call you.

FIRST: cell/home/work ____ - ____ - ____ SECOND: cell/home/work ____ - ____ - ____

EMAIL ADDRESS _____ I Would Like To Receive Updates Via E-Mail.

MARITAL STATUS: SINGLE MARRIED DIVORCED WIDOWED

OCCUPATION: _____ EMPLOYER: _____

WORK ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

IN CASE OF EMERGENCY, CONTACT: _____ NUMBER ____ - ____ - ____

RELATIONSHIP OF THE EMERGENCY CONTACT TO PATIENT: _____

HOW DID YOU FIND OUT ABOUT DR. BONAKDAR & BEAUTY, LASER & WELLNESS CENTER?

Personal Referral: Who may we thank for referring you? _____

Website/Search Engine: Which one? _____ OTHER: Please Specify: _____

IDENTITY THEFT PROTECTION

Please record your Driver's License information below and give your ID to the client coordinator to copy.

DRIVER'S LICENSE STATE: _____ NUMBER: _____