

**ANTI-AGING ARTS MEDICAL CENTER**  
**ROBERT F. STERNER, JR., MD, ABAAM**  
**619-543-1061/619-543-0043Fax**

**Patient Information:**

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

Street Address: \_\_\_\_\_

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

HM Phone: (    ) \_\_\_\_\_ WK Phone: (    ) \_\_\_\_\_ Ext \_\_\_\_\_

Cell Phone: (    ) \_\_\_\_\_ Pager: (    ) \_\_\_\_\_

Please indicate where you wish to receive phone calls discreetly: (    ) Home (    ) Work (    ) Never

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex: (    ) Male (    ) Female Social Security: \_\_\_\_\_

Referred by: (    ) Yellow Pages (    ) Friend \_\_\_\_\_ (    ) Other \_\_\_\_\_

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

**In Case of Emergency, Contact:**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_ City, State, Zip: \_\_\_\_\_

HM Phone: \_\_\_\_\_ WK Phone: \_\_\_\_\_ Other: \_\_\_\_\_

**Visit Information:**

Reason for coming the office: \_\_\_\_\_

Please list other doctors you are currently seeing: \_\_\_\_\_

Weight control patients only: Please list other structured programs you have been on, Physician's name and the city/state of the program (use reverse if necessary): \_\_\_\_\_

I hereby apply for services and give my consent for treatment of: (    ) myself, or (    ) minor child \_\_\_\_\_  
\_\_\_\_\_. I guarantee payment of all charges incurred by the above patient and understand that I am responsible for all charges payable with credit card, check or cash at the time of service. I understand that with any medication I need to be careful while operating a motor vehicle or performing hazardous activities.

Signed \_\_\_\_\_ Date \_\_\_\_\_