Todays Date:_____

PATIENT INFORMATION

Name:_____
Last First M.I.

Address:_____
Street Apt# City State zip

Home phone _____ Work phone _____ Cell phone_____

Marital Status:(√ one)_____Single_____Married_____Widowed_____Divorced_____Other SS#: _____

Date of Birth_____ Age_____ Sex:_____ Email address:_____

Preferred language _____ Ethnicity(√ one)____Hispanic or Latino _____Not Hispanic or Latino___Unknown

Race:(√ one below)
_____American Indian/Alaska Native_____Asian_____Black/African American_____Native Hawaiin/other Pacific Islander_____White____Other Race

Patient's Employer:_____(or √ one) ☐ FT student ☐ PT student ☐ Retired ☐Unemployed

NAME OF RESPONSIBLE PARTY (if different from patient)_____SS#_____

Mailing address of responsible party_____
Street City State Zip

Home phone_____ Cell phone_____ Date of Birth_____Relation_____

INSURANCE INFORMATION:

After you have finished completing this form please bring it to the front desk along with your current insurance card and photo ID

Primary Insurance Co. Name_____
Name of Insured:_____
Relationship to Insured:_____
Insured BD:_____Insured SS#:_____

Secondary Insurance Co. Name:_____
Name of Insured:_____
Relationship to Insured:_____
Insured BD:_____Insured SS#:_____

In case of Emergency who should be notified?_____ Phone:_____
Primary care physician:_____ Location:_____Phone #_____
Pharmacy Name:_____ Location:_____Phone #_____
Who referred you to our office, if not your physician?_____

Patient Authorization:

I authorize the release of medical information to my primary care or referring physician, to consultants if needed and as necessary to process insurance claims, insurance applications, and prescriptions. I also authorize payment of medical benefits to the provider. I understand that I am responsible for notifying the office 24 hrs in advance to cancel appt.

Payment is required for all services at the time they are rendered unless you are in an insurance plan in which we participate. For those patients, applicable copayments, co-insurance and deductibles will be expected to be collected prior to seeing the provider. If your check does not clear the bank, a $25 service fee will automatically be added to your account. A $10 feel will be added monthly to the account if not paid in full after the 1st statement is sent out. Understand any procedure performed in the office may be billed separately in addition to the office visit fee. A $50 deposit will be required in advance for all cosmetic procedures, and forfieted if the appointment is not cancelled 24 hours in advance.

My signature below signifies my understanding and willingness to comply with the above policies

Patient/Parent or Responsible party signature_____ Date:_____