Patient's Name_____
(Mr. Mrs. Miss Ms. Dr. Sr. Fr.)
Date of Birth_____ Age_____
Gender_____ Race/Ethnicity_____
Preferred Language_____
Spouse _____ Parents Name_____
(If patient is under 18 years old)
Home Address_____
City_____ State_____ Zip Code_____
Home Phone_____ Work_____
Cell Phone_____ Fax _____
E-
mail_____
Referred by_____ _____
Any allergies? Please List_____
What Medications Are You Taking?_____
_____
Do You Smoke?_____
Medical Illnesses_____
Social Security #_____
Medicare #_____

(Please fill in reverse side.)

You will be given a signed receipt each time you are seen. Attach this to your Insurance Form and mail directly to your Insurance Company.

YOU ARE RESPONSIBLE FOR ALL FEES, REGARDLESS OF INSURANCE COVERAGE. PLEASE PAY FOR SERVICES WHEN RENDERED. THANK YOU.

_____ _____
SIGNATURE DATE

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(Mr. Mrs. Miss Ms. Dr. Sr. Fr.)
Date of Birth_____
Age_____
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_____ _____
SIGNATURE DATE

Name_____
(Please Print Clearly)

☐Because of new governmental privacy policies, we need permission to leave a message for you about appointments, lab results, biopsy results, questions or comments:

	YES	NO
On your home machine or voice mail.	_	_
On your office machine or voice mail.	_	_
On your cell phone voice mail.	_	_
With a spouse or parent.	_	_

_____
Signature

_____
Date

☐Health issues of interest to you (please check all that apply):

_	Skin Care/Sunscreen advice	_	Botox® Cosmetic
_	Skin Care products	_	AHA and glycolic peel
_	Skin Cancer	_	Fillers for wrinkle lines
_	Age spots	_	Skin rejuvenation
_	Facial Veins	_	Discoloration
_	Acne		
_	IPL/Photofacial	_	Other, please specify:

_____

☐If you are over 65, indicate what type of insurance coverage you have:

PPO HMO Other_____

Primary_____

Secondary_____

Medicare
#_____
Name_____
(Please Print Clearly)

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Medicare
#_____