

## ***Patient Information Record***

Name _____				Date _____			
Address _____				_____			
<small>Address</small>		<small>City</small>		<small>State</small>		<small>Zip Code</small>	
Home Phone (    ) _____		Age _____		Sex _____			
Work Phone (    ) _____		Employer _____					
Date of Birth ____ / ____ / ____		SS# ____ - ____ - ____		Driver's License # _____			
Spouse's Name _____				Spouse's Employer _____			
Spouse's Work Phone (    ) _____		Date of Birth ____ / ____ / ____		SS # ____ - ____ - ____			
In Case of an Emergency, Contact _____				Phone Number (    ) _____			
Preferred Method of Payment    (    ) Cash    (    ) Check    (    ) Credit Card    (Master Card/Visa/Discover)							

### ***If Patient is a Minor or Student***

Mother's Name _____				Date of Birth ____ / ____ / ____				SS# ____ - ____ - ____			
Address _____				_____				_____			
<small>Address</small>		<small>City</small>		<small>State</small>		<small>Zip Code</small>					
Home Phone (    ) _____				Work Phone (    ) _____							
Father's Name _____				Date of Birth ____ / ____ / ____				SS# ____ - ____ - ____			
Address _____				_____				_____			
<small>Address</small>		<small>City</small>		<small>State</small>		<small>Zip Code</small>					
Home Phone (    ) _____				Work Phone (    ) _____							

### ***Insurance***

Name of Insurance Company \_\_\_\_\_ Insured I.D. # \_\_\_\_\_

### ***Reason for Visit***

<input type="checkbox"/> Dermatology Problem _____	<input type="checkbox"/> Skin Cancer _____
Laser Surgery for: <input type="checkbox"/> Wrinkles <input type="checkbox"/> Acne Scarring	<input type="checkbox"/> Birthmark _____
<input type="checkbox"/> Blood Vessels <input type="checkbox"/> Tattoo	<input type="checkbox"/> Age Spots _____
<input type="checkbox"/> Vein Treatment <input type="checkbox"/> Chemical Peel	<input type="checkbox"/> BOTOX <input type="checkbox"/> Microdermabrasion
<input type="checkbox"/> Healthy Skin Program <input type="checkbox"/> Collagen	Other _____

Referred by: \_\_\_\_\_

I have completed this form fully and completely, and certify that I am the patient or duly authorized general agent of the patient authorized to furnish the information requested. I understand that even though I have some type of insurance coverage, I am responsible for payment of services, at the time services are rendered. I authorize the release of information to my insurance company and also the authorization to release medical information to other physicians regarding my care.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date