PLEASE PRINT CLEARLY

PATIENT INFORMATION*:** ***DATE:_____

Last Name: _____ First: _____ M.I._____

Street Address _____

City _____ State _____ Zip Code _____

Date of Birth: _____ Age: _____ Gender: (M) (F) Height:_____ Weight:_____

Social Security #:_____ Marital Status: (S) (M) (D) (W)

Home Phone: _____Work Phone: _____Cell Phone: _____

Preferred method of contact: Phone: (Home) (Work) (Cell)

Email: _____

Employer: _____ Occupation: _____

IF UNDER 18 YRS OF AGE, PARENT/GUARDIAN NAME : _____

Emergency Contact: _____ Phone No: _____ Relationship:_____

Referring Physician:_____ Primary Care Physician:_____

How did you hear about us? (mark all that apply)

❒ Website ❒Search Engine ❒Friend ❒Insurance Co. ❒Other:_____

❒**Referring Physician:**_____

INSURANCE INFORMATION:

PATIENTS ARE REQUIRED TO PRESENT PROOF OF INSURANCE COVERAGE PRIOR TO SERVICES. OTHERWISE, PATIENT WILL BE RESPONSIBLE FOR FULL PAYMENT OF SERVICES AT THE TIME OF THE VISIT.

Primary Ins. Co: _____

Are you the primary insured? Yes / No *(IF NO FILL OUT THE FOLLOWING FOR PRIMARY INSURED)*

Policy Holder's Name:_____ DOB: _____ Gender: M F

Relationship to Patient: _____ Social Security No: _____

Are you covered by a secondary insurance? Yes / No

Secondary Ins. Co: _____

Policy Holder's Name:_____ DOB: _____ Gender: M F

Relationship to Patient: _____ Social Security No: _____

We Do Not File Cosmetic Procedures With Insurance…Breast Augmentation, Liposuction, Abdominoplasty, Facelifts, Gynecomastia, etc. and any procedures resulting from extreme weight loss.