

***Patient Information***

Mr.  Mrs.  Ms.  Dr. First Name: \_\_\_\_\_ M.I. \_\_\_\_\_ Last Name \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Email Address: \_\_\_\_\_  
Gender:  Male  Female Marital Status:  Single  Married  Widowed  Divorced  Other  
Home Phone #: \_\_\_\_\_ Work Phone #: \_\_\_\_\_ Cell Phone #: \_\_\_\_\_  
Preferred contact phone number:  Cell Phone  Home Phone May we contact your home and leave a message with other residents?  YES  NO IF yes, with whom are we authorized to leave messages?  
\_\_\_\_\_ Relationship to Patient: \_\_\_\_\_  
May we leave messages on your answering machine or home voice mail?  YES  NO  
May we send and receive information with you via the internet?  YES  NO

***Medical Information***

Reason for today's visit (please check all that apply):  Breasts  Waist/Abdomen  Skin  Face  
 Forehead  Eyes  Lips  Neck  Thighs  Legs  Back  Body  Buttocks  Suspicious Lesion  
 Cyst  Reconstructive Procedure: \_\_\_\_\_  Other: \_\_\_\_\_  
Accident?  YES  NO If yes, date: \_\_\_\_\_ Auto Accident?  YES  NO If yes, date: \_\_\_\_\_  
How did you hear about us? Referred by: \_\_\_\_\_  
 Friend/Relative/Other patient: \_\_\_\_\_  Website: \_\_\_\_\_  
 Yellow Pages: \_\_\_\_\_  Print ad: \_\_\_\_\_ (please identify)  
Primary Care Physician: \_\_\_\_\_ Primary Care Phone #: \_\_\_\_\_

***Patient's Employment Information***

Employer: \_\_\_\_\_  
Employer's Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Occupation: \_\_\_\_\_ Employment Status:  Full Time  Part Time  Not employed  
 Self Employed  Retired  Full Time Student  Part Time Student

***Financial Responsibility***

I understand and agree that regardless of my insurance status and regardless of any insurance prior approvals, I am ultimately responsible for the entire balance of my account for any professional services rendered.

I have read all the information and have completed all answers. I certify that the foregoing information is true and correct. I will notify you promptly of any changes in my status or in the above information.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_  
(Parent/Legal Guardian if patient is under 18 years old)