LAST NAME: ______________________________ FIRST NAME: _____________________________MIDDLE INITIAL: ______

ADDRESS: ________________________________CITY: ______________________ ST: _________________ ZIP: _________

PRIMARY PHONE: ___________________ SECONDARY PHONE: ______________________WORK PHONE: ______________

BIRTH DATE: _______________________ SEX: *MALE or FEMALE* MARITAL STATUS: *SINGLE MARRIED DIVORCED WIDOWED*

SOC SEC# ___________________ EMPLOYER________________________ OCCUPATION ____________________________

EMERGENCY CONTACT: ___________________________ RELATIONSHIP ____________________ PHONE _____________
(different than self) (different than own phone #)

INSURANCE INFORMATION

PRIMARY: ______________________________________ ID# ____________________________ GROUP# _______________

SECONDARY: ___________________________________ ID# _____________________________GROUP# ______________

E-MAIL: ____ Preferred Language __________________

ETHNICITY: (please circle one) *Latin/Hispanic* *Non-Latin/Hispanic* *Refuse to Report* Race: ______________________________

PHARMACY _______________________________ ADDRESS _________________________________ PHONE ____________

MAIL-AWAY PHARMACY _________________________ ADDRESS ____________________________ PHONE ____________

ARE YOU INTERESTED IN: □ *Medically Assisted Weight Loss* □ *Laser Hair Removal* □ *Botox/Anti-Aging Treatments*

BILLING INFORMATION

All professional services rendered are the responsibility of the patient. Necessary forms will be completed to help expedite insurance carrier payments. However, the patient is responsible for all fees, regardless of insurance coverage. If it is necessary to turn over to collection for non-payment after 120 days, then the patient is responsible for the bill, interest, and attorney fees.

AUTHORIZATION TO PAYN BENEFITS TO PHYSICIAN: I hereby authorize payment directly to the undersigned Physician for my charges.

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize the undersigned Physician to release any information acquired in the examination or treatment to insurance company in writing or by fax.

MEDICARE STATEMENT (if applicable): This claim will be submitted to Medicare for you by our office. Medicare may not cover some services, which the patient will be responsible to pay. Such identified services include yearly physicals. In addition, you will be responsible for your yearly Medicare deductible and coinsurance if you do not subscribe to supplemental policy.

SIGNATURE ____ **DATE** ______________________________