

PATIENT INFORMATION

Thank you for choosing our office. In order to serve you properly, we need the following information. Please print. All information will be kept confidential.

PATIENT Name \_\_\_\_\_  Male  Female Birthdate: \_\_\_\_\_  
First Middle Last

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ SSN: \_\_\_\_\_

Home Address: \_\_\_\_\_  
Street City State Zip Code

Email Address: \_\_\_\_\_ Driver's License #: \_\_\_\_\_

Check Appropriate Box:  Minor  Single  Married  Divorced  Widowed  Separated

Employer: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Employer Address: \_\_\_\_\_  
Street City State Zip Code

Spouse / Parent Name \_\_\_\_\_ Work Phone: \_\_\_\_\_ Employer: \_\_\_\_\_

If a student, please give us the name of school: \_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_

Person to contact in case of an emergency? \_\_\_\_\_ Phone: \_\_\_\_\_

**RESPONSIBLE PARTY**

Person financially responsible (if other than patient): \_\_\_\_\_ Relationship: \_\_\_\_\_

Home Address: \_\_\_\_\_  
Street City State Zip Code

Email Address: \_\_\_\_\_ Driver's License #: \_\_\_\_\_ Birthdate: \_\_\_\_\_

Employer: \_\_\_\_\_ Work Phone: \_\_\_\_\_

**INSURANCE INFORMATION-** We require current insurance cards and insurance information at time of service or your appointment may be rescheduled.

Primary Insurance Plan: \_\_\_\_\_ Secondary Insurance Plan: \_\_\_\_\_

**RELEASE**

I authorize release of any information concerning my (or my child's) health care, advice and/or treatment provided for the purpose of evaluating and administering claims for insurance benefits. I also hereby authorize payment of insurance benefits to go directly to The Aesthetic Surgery Centre'. I agree to be personally and financially responsible for payment in full for services I receive, regardless of my insurance coverage, referral procedure, or third party claims.

X \_\_\_\_\_ Date \_\_\_\_\_  
Patient Signature or parent/guardian if minor