PATIENT INFORMATION FORM

Please Print

First Name:_____Last Name:_____

Street Address:_____

City:_____ State:_____ Zip:_____Email:_____*

* We do not share mailing list information.

By providing your e-mail address you agree to receive special promotion offers, newsletter s and event information from our office.

Home: ( ) _____ Work: ( ) _____ Cellular: ( ) _____

Date of Birth: _____ Social Security: _____- _____-_____

M _____ F _____ Marital Status _____ Referred by: _____

Occupation: _____ Employer Name:_____

Insurance Company: _____ ID #:_____

Insured:_____Date of Birth and SS # of Insured: _____

Please have insurance card(s) available for photocopy (for either Insurance or Cosmetic purposes)

Emergency Contact: _____ Phone: _____

Primary Care Physician: _____ Phone: _____

Is this visit the result of an accident? _____ Date of Accident: _____

Name and address of attorney (if applicable) _____

Workman Compensation Insurance Company (if applicable) _____

INFORMED CONSENT AND PRIVACY POLICY INFORMATION

In order to provide service to you, we are participants in most managed care insurance plans. To insure coverage, please call the telephone number on the back of your insurance card. We bill insurance companies directly as a courtesy to all of our patients. It is your responsibility to obtain an insurance referral when applicable.

If this visit is the result of an accident, your insurance company may be billed under your Personal Injury Protection clause until coverage is exhausted. If you have an attorney, please fill out the form accurately. The attorney may determine how to bill your charges. A referral, if applicable, may still be necessary.

We will protect the confidentiality of your private health information as required by law. This information may be disclosed to other health care or private administrators in the normal course of your care and treatment.

By signing this form, I acknowledge the following unless otherwise noted:

- ☐ I authorize treatment of the above named patient.
- ☐ I acknowledge responsibility for obtaining referrals when necessary or applicable.
- ☐ I acknowledge responsibility of payment of charges incurred or otherwise not covered.
- ☐ Personal health history information, office notes, reports, correspondence and/or photographs are the property of this office.
- ☐ Personal health history information, office notes, reports, correspondence and/or photographs may be used or disclosed to and/or requested from other health care professionals or insurance company professionals for treatment, payment or other health care operations.
- ☐ This office may require an additional signed consent form prior to the release of your private health history information, office notes, reports, correspondence and/or photographs to yourself or other individuals not mentioned above.
- ☐ I authorize photographs to be taken if necessary. These photographs may be used in clinical presentations without any patient identification to protect privacy.
- ☐ You may revoke this consent unless the information has already been used or disclosed in good faith on your behalf prior to revocation.
- ☐ You may request that this office restrict the use of or disclosure of your personal health history information, office notes, reports, correspondence and/or photographs for treatment, payment or other health care operations. Restrictions may affect treatment and/or reimbursement of charges. Restrictions must be in writing.

  Changes in State or Federal regulations may cause amendments to the above without specific notice.

Signature: _____ Date:_____