

ALLURA SKIN AND LASER CENTER, APC

Bruce L. Maltz, M.D. • Carie T. Chui, M.D.

PATIENT INFORMATION					
LAST NAME	FIRST NAME	MI	BIRTHDATE	SOCIAL SECURITY #	
HOME ADDRESS	CITY	STATE	ZIP	SEX	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE
HOME #	CELL #	WORK #	E-MAIL ADDRESS		
INSURANCE INFORMATION					
Is your insurance an HMO? Yes No					
PRIMARY INSURANCE	SOCIAL SECURITY #	CARDHOLDER	DATE OF BIRTH		
GROUP NUMBER	IDENTIFICATION NUMBER	EMPLOYER NAME			
SECONDARY INSURANCE	SOCIAL SECURITY #	CARDHOLDER	DATE OF BIRTH		
GROUP NUMBER	IDENTIFICATION NUMBER	EMPLOYER NAME			
RESPONSIBLE PARTY INFORMATION (IF SAME AS ABOVE CHECK HERE _____)					
RESPONSIBLE PARTY NAME	LAST	FIRST	MI	RESPONSIBLE PARTY PHONE #	
RESPONSIBLE PARTY ADDRESS	CITY	STATE	ZIP	SOCIAL SECURITY #	
RESPONSIBLE PARTY EMPLOYER	RESPONSIBLE PARTY WORK #		RESPONSIBLE PARTY DATE OF BIRTH		
RELATIONSHIP TO PATIENT	<input type="checkbox"/> SPOUSE <input type="checkbox"/> MOTHER <input type="checkbox"/> FATHER <input type="checkbox"/> OTHER				
EMERGENCY CONTACT	RELATIONSHIP		PHONE #		
TOPICS OF INTEREST TO YOU (CHECK ALL THAT APPLY)					
<input type="checkbox"/> BOTOX	<input type="checkbox"/> LASER SKIN TREATMENT	<input type="checkbox"/> SKIN CARE PRODUCTS			
<input type="checkbox"/> COLLAGEN/RESTYLANE	<input type="checkbox"/> AGE/LIVER SPOTS	<input type="checkbox"/> SCAR/WRINKLE REDUCTION			
<input type="checkbox"/> LASER HAIR REMOVAL	<input type="checkbox"/> LIPOSUCTION	<input type="checkbox"/> TATTOO REMOVAL			
<input type="checkbox"/> CHEMICAL/ACID PEELS	<input type="checkbox"/> LEG VEIN REMOVAL	<input type="checkbox"/> FACIAL VEINS			
<input type="checkbox"/> FACIALS	<input type="checkbox"/> SUN PROTECTION	<input type="checkbox"/> OTHER _____			
WHO MAY WE THANK FOR REFERRING YOU?					
NAME	<input type="checkbox"/> PATIENT <input type="checkbox"/> DOCTOR <input type="checkbox"/> ADVERTISEMENT <input type="checkbox"/> PHONE BOOK				
<p>I, the patient, or I the legal guardian of the patient, consent to treatment by Bruce L. Maltz, M.D., Carie T Chui, M.D. or their qualified staff, and agree to be responsible for account balances, regardless of anticipated insurance payment. Where insurance does not cover services known to be medically unnecessary or cosmetic in nature, I agree to be responsible for payment at the time service is rendered and that my insurance company cannot be later billed for these charges. I agree to pay copayments and unmet deductibles, and present primary care referrals and accurate insurance information at the time of service according to the agreement I made with my insurance plan as a subscriber. If I elect to have services without a referral, I will waive the requirement that my insurance carrier be billed and make payment in full at the time of service, or it is my option to reschedule at a time when I can provide this referral. I authorize the release of medical information from my files for the purpose of claims processing or the management of my healthcare. Should I fail to notify the staff of Allura Skin and Laser Center of any changes in my personal information and insurance, I will bear the cost of collection of any balances due. I agree to notify the office 24 hours in advance if I cannot keep an appointment and understand that failure to do so may incur a charge.</p>					
SIGNATURE OF PATIENT IF OVER AGE 18 (LEGAL GUARDIAN)			DATE		
PRINT NAME IF NOT PATIENT _____			RELATIONSHIP _____		