

**ALLURA SKIN & LASER CENTER, INC**

**Patient Information: PLEASE PRINT**

**THIS SECTION MUST BE COMPLETED FOR ALL PATIENTS:**

Today's Date \_\_\_/\_\_\_/\_\_\_

Name \_\_\_\_\_  
Last First M.I.

Date of Birth: \_\_\_/\_\_\_/\_\_\_ Gender:  Male  Female Preferred Language: \_\_\_\_\_

Race:  American Indian or Alaska Native  Asian  Native Hawaiian or Other Pacific Islander  
 Black or African American  Hispanic or Latino  White  Decline to Answer

**ADDRESS:**

Mailing Address \_\_\_\_\_  
Street City State Zip

Home Phone: ( ) \_\_\_\_\_ Work Phone: ( ) \_\_\_\_\_

Cell Phone: ( ) \_\_\_\_\_ e-mail: \_\_\_\_\_

**May we e-mail personal medical information to you?**  YES  NO

**May we leave personal medical information on your answering machine or cell phone?**  YES  NO

**INSURANCE COVERAGE - PRIMARY:**

Insurance Co. Name: \_\_\_\_\_

Name of Policy Holder (Insured): \_\_\_\_\_

Policy Holder (Insured) Date of Birth: \_\_\_/\_\_\_/\_\_\_

If patient is child, check relationship to insured:  Mother  Father  Other \_\_\_\_\_

**INSURANCE COVERAGE - SECONDARY:**

Insurance Co. Name: \_\_\_\_\_

Name of Policy Holder (Insured): \_\_\_\_\_

Policy Holder (Insured) Date of Birth: \_\_\_/\_\_\_/\_\_\_

If patient is child, check relationship to insured:  Mother  Father  Other \_\_\_\_\_

**EMERGENCY CONTACT INFORMATION:**

In case of Emergency, who should be notified? \_\_\_\_\_ Phone ( ) \_\_\_\_\_

Relationship to patient: \_\_\_\_\_

**Do you give our office permission to discuss your medical information with family members?**

YES  NO If yes, please provide their names and phone numbers below.

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Phone # (day): (\_\_\_\_\_) \_\_\_\_\_ Phone # (evening): (\_\_\_\_\_) \_\_\_\_\_

**Please complete the other side of this form**

**REFERRAL INFORMATION**

Referred by: \_\_\_\_\_

Primary Care Physician \_\_\_\_\_ Phone (    ) \_\_\_\_\_

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, 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 a 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 at Allura Skin & Laser Center, Inc. of any changes in my personal information and insurance, I will bear the cost of collection of any balances due which may include a late fee. 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.

\_\_\_\_\_  
SIGNATURE OF PATIENT IF OVER AGE 18 (LEGAL GURADIAN) \_\_\_\_\_  
DATE

PRINT NAME IF NOT PATIENT \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_

ADDRESS: \_\_\_\_\_  
Street City State Zip

PHONE: \_\_\_\_\_ DATE OF BIRTH: \_\_\_/\_\_\_/\_\_\_