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 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: ___/___/___