

PATIENT NAME (Last) (First) (M.I.)			ACCT#	DATE
			AGE	BIRTHDATE
MARITAL STATUS (Circle one) Single Married Divorced Separated Widowed	PATIENT SEX (Circle one) M F	SOCIAL SECURITY #	SPOUSES 1ST NAME	MAIDEN NAME
ADDRESS			HOME PHONE	
CITY	STATE	ZIP	WORK PHONE	
OCCUPATION	EMPLOYER NAME		CELL PHONE	
ADDRESS			ZIP	
CITY			STATE	

MAY WE EMAIL YOU?(Circle one) Yes NO		EMAIL
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EMERGENCY CONTACT:	RELATIONSHIP	PHONE #
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ALLERGIES

FAMILY DR.	PHONE #
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PHARMACY	PHONE #
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REFERRING DR.	PHONE #
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RESPONSIBLE PARTY NAME (If other than yourself)	RELATIONSHIP
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RESPONSIBLE PARTY ADDRESS

TELEPHONE	SOCIAL SECURITY #	DATE OF BIRTH
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OCCUPATION	EMPLOYER	BUSINESS PHONE
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EMPLOYER ADDRESS

How Did You Hear About Us?		
<input type="checkbox"/> Physician <input type="checkbox"/> Website <input type="checkbox"/> National Media <input type="checkbox"/> Magazine <input type="checkbox"/> Internet	<input type="checkbox"/> Newsletter <input type="checkbox"/> Seminar <input type="checkbox"/> Friend/Family <input type="checkbox"/> Open House <input type="checkbox"/> Groupon	<input type="checkbox"/> Newspaper <input type="checkbox"/> Another person not listed above <input type="checkbox"/> Research <input type="checkbox"/> Radio <input type="checkbox"/> Yellow Pages <input type="checkbox"/> Other _____

TREATMENT AND FINANCIAL AGREEMENT: I hereby apply for treatment by the Laser & Cosmetic Center of Virginia and/or their assistant. I accept full responsibility of any charges incurred for services rendered. In the event of default on any payments due the Laser Skin & Vein Center of Virginia, I agree to pay all costs of collection including 33 -1/3% attorney's fees.

INSURANCE ASSIGNMENT: I hereby authorize the Laser & Cosmetic Center of Virginia to bill my insurance company on my behalf and to receive direct payment of any amounts due to my claim under the above policy or policies. I understand that I am responsible for all charges not covered by my benefits due under this authorization. Release of information necessary for the completion of insurance forms is authorized.

MEDICAL AUTHORIZATION: I hereby give permission to all doctors and hospitals to release all films or other medical records they have on me to the Laser & Cosmetic Center of Virginia. I hereby give permission to the Laser & Cosmetic Center of Virginia to release any information required by my medical insurance payor for the purpose of filing my insurance claims.

DATE _____ SIGNATURE _____