Please PRINT. All information must be completed. If not applicable, please mark N/A.

Full Name:			Gender:
Date of Birth:	If Minor, Responsible Parent Name:		
Marital Status: ☐ Married ☐ Divorced ☐ Single ☐ Widowed ☐ Separated			
Home Address:	City:	State:	Zip:
Home Phone:	Cell Phone:		
Work Phone:	Email Address:		
How did you hear about us:			
Preferred contact method for appointment reminder:	Home	Cell	Text Email None
Would you like to receive emails regarding special events, discounts, and cosmetic services:	☐ Yes	☐ No	

After your visit you may receive a patient satisfaction survey via text, email or paper. We kindly ask that you complete this survey.

Primary Care Physician Name:	PCP Phone #:	
Referring Physician Name (if different from above):	Ref Phys #:	

Emergency Contact:	Relationship:	Phone #:

MEDICAL INSURANCE INFORMATION:

Primary Insurance:	Patient Policy#	
Group Name or Number:	Claims Address:	
Insured Party's Name:	Insured's DOB:	
Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other	Insured's SSN#:	
Secondary Insurance:	Patient Policy#	
Group Name or Number:	Insured Party's Name:	
Insured's DOB:	Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other	
Insured's SSN#:		

I acknowledge that the information provided is complete and accurate.

Signature of Patient or Guardian	**Printed Name**	**Date**