

Aesthetic Surgical Arts & Skin Enhancement Center

PERSONAL INFORMATION (Please Print)

Date _____

Name _____

Address _____ City _____ State _____ Zip _____

Phone: Home (_____) _____ Work (_____) _____

If we cannot reach you directly by phone, may we leave a message? Yes No

Occupation _____ Employer _____

Address _____ City _____ State _____ Zip _____

Date of Birth _____ Age _____ M/F _____ Social Security# _____

Marital Status: Single Married Widowed Divorced E-mail Address _____

REFERRED BY: Friend/Relative _____ Doctor _____

Yellow Pages Television Newspaper Other _____

Are you interested in learning more about the professional skin care products that Dr.

Hunts recommends? Yes _____ No _____

Complete if you would like anyone to have access to your medical records other than yourself Name _____ Relationship: _____

Address _____ Phone (_____) _____

Complete if under 18 years of age or a student

Name of Parent _____ Employer _____

Address _____ Phone (_____) _____

INSURANCE INFORMATION (Please bring insurance card to your appointment)

See attached card No Insurance to be billed

If Insurance is through Spouse or Parent please include the following:

Name _____

SS# _____ Birth Date _____

Are you personally responsible for the payment of your fees?

Yes No If not, who is?

Name _____ Relationship _____

Address _____ City _____ State _____ Zip _____

Home Phone (_____) _____ Work Phone (_____) _____

FINANCIAL ASSIGNMENT AND AGREEMENT:

1. Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. **It is your responsibility to pay any deductible amount, co-insurance, or any other balance not paid for by your insurance.**
2. I request that payment of authorized Medicare and/or insurance benefits be made on my behalf for any services furnished me. I authorize any holder of medical information about me to release to the Health Care Financing Administration, its agents, or any insurance carrier I may have, any information needed to determine their benefits or the benefits payable for related services.
3. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure the payment.

SIGNED (Patient or parent if minor) _____ Date _____

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Verify Photo ID