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| Patient Information | |
| Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Last Name First Name Middle Initial  Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_\_ Sex: \_\_\_M \_\_\_F Social Security Number: XXX-XX-\_\_\_\_\_\_\_\_\_  Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  City, State, Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Home Phone: ( \_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone: (\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  May we leave messages for you? Y/N Which number do you prefer? Home/Cell/Both  Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
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| Race: \_\_American Indian or Alaska Native \_\_Asian  \_\_Black or African American  \_\_Native Hawaiian or Other Pacific Islander \_\_White \_\_Decline  Ethnicity: \_\_Hispanic/Latino \_\_Non Hispanic/Non Latino \_\_Decline  Primary Language: \_\_English \_\_Spanish \_\_\_Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| Emergency Information | |
| Emergency Contact Person: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Relationship:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Phone (Other than home number) (\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| Insurance Information  *Please provide a copy of insurance cards and picture ID to our Patient Coordinator* | |
| Primary Insurance: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Policy Holder’s Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Policy Holder’s Date of Birth: \_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_  Your Relationship to Policy Holder:\_\_\_\_\_\_\_\_\_\_\_\_  Co-Pay: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Secondary Insurance: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Policy Holder’s Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Policy Holder’s Date of Birth: \_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_  Your Relationship to Policy Holder:\_\_\_\_\_\_\_\_\_\_\_\_  Co-Pay: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Insurance Authorization for Assignment of Benefits/Information Releases:**  I, the undersigned authorize payment of medical benefits to Luxe Laser for any services furnished me by the practice. I understand that I am financially responsible for any amount not covered by my contract. I also authorize you to release to my insurance company or their agent information concerning health care, advise, treatment or supplies provided to me. This information will be used for the purpose of evaluation and administration claims of benefits.  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Patient, Parent or Guardian Signature (If child is under 18 years old) Date | |