Patient Information

Name: ____

Last Name First Name Middle Initial

Date of Birth: ____/____/______ Sex: ___M ___F Social Security Number: XXX-XX-__________

Address: ____

City, State, Zip: ____

Cell Phone: (____) ________________________ Home Phone: (____) ________________________

May we leave messages for you? Y/N Which number do you prefer? Home/Cell/Both

Email: ________________________________

Preferred Pharmacy: ____________________________________ Phone: (_____) ______________

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

Emergency Contact Information

Emergency Contact Person: ____

Relationship: ____

Cell Phone: (____) ____

Insurance Information

Please provide insurance cards to be copied

Primary Insurance: ________________________	Secondary Insurance: ______________________
Policy Holder's Name: _____________________	Policy Holder's Name: _____________________
Policy Holder's Date of Birth: ____/____/______	Policy Holder's Date of Birth: ____/____/______
Your Relationship to Policy Holder: ___________	Your Relationship to Policy Holder: ___________
Co-Pay: ___________________	Co-Pay: ___________________

Authorization for Information Release:

I authorize Luxe Laser 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 patient is under 18 years old) Date