Please circle: Mr. Mrs. Ms. Miss Dr.

Patient Name: ____Date:_______________
Last First Middle initial

Home Address:______________________________City:_____________ State:____Zip:______

Telephone:____
Home Cell Work

Birth Date:_________ SSN:_______________Email Address:____________________________

Occupation:___________________________________Employer:_________________________

Health Insurance Carrier:______________________________Guarantor:_____________________

Relationship to Guarantor:______________________________Guarantor Date of Birth:__________

Secondary Insurance Carrier:___________________________Guarantor:_____________________

Relationship to Guarantor:______________________________Guarantor Date of Birth:__________

Emergency Contact:_____________________ Emergency Number:_________________________

Pharmacy Name and City:____

Communications

May we leave negative (benign) test results on your home phone answering machine or cell phone? Y N

If unreachable via telephone may we send you correspondence via mail? Y N

Patient Release

I certify that the information that I have provided is correct. I authorize the release of medical information necessary to process insurance claims to insurance companies or their agencies (including Medicare) for purpose of filing and payment of medical claims. I authorize payment of medical benefits to the provider.

I certify that I hereby authorize SOMA Skin & Laser, its providers and staff to provide my minor child in my absence with examinations and basic treatment for which additional consents are not required. I understand as the legal guardian of this child I am required to be physically present to consult with the provider on any procedures which require separate consent such as surgery, biopsy, or wart destructions. I understand additional written consent may be necessary for these types of procedures and that the legal guardian must be present for such consent.

Signature of Patient/Parent/Guardian:___________________________________ Date:______________