Name: ______________________________

Responsible Party: ______________________________

Street Address: ______________________________

Zip Code: ____________ *City:* ____________ *State:* ____________

Home Phone: ____________ *Work Phone:* ____________

Cell Phone: ____________ *E-mail:* ____________

Marital Status: ____________ *Date of Birth:* ___-___-___ *SSN:* ___-___-___

Referred by: (please check the appropriate box and specify the name of the person who sent you so that we may thank them)

Doctor ____________ *Friend/Family* ____________

Advertisement ____________ *Internet* *Other* ____________

Insurance PRIMARY: ____________ *ID#* ____________

Insurance SECONDARY: ____________ *ID#* ____________

Subscriber Name: ____________ *Group#* ____________

Race/Ethnicity: ____________ *Language:* ____________

Primary Care Physician: ______________________________

Education: ________ *Employer:* ____________ *Occupation:* ____________

Emergency Contact: ____________ *Emergency Phone Number:* ____________

Spouse's Name: ______________________________

Spouse's DOB: ___-___-___ *Spouse's SSN:* ___-___-___

If you are a minor, parent's name and address: ______________________________

**We offer the following laser treatments:*

Hair Removal *Vein Treatment* *Genesis – Skin Treatment*

Would you like more information? *(Please circle one)* YES NO

Assignment of Benefits-Financial Agreement

Insurance will be billed for all PPO's, HMO's and EPO's with which we are contracted. We accept assignment for Medicare. PLEASE NOTE THAT YOU ARE RESPONSIBLE FOR PAYMENT OF ALL FEES FOR PROFESSIONAL SERVICE EVEN THOUGH YOU MAY HAVE INSURANCE COVERAGE – this means that should the insurer fail to pay any sums due, you are responsible for the payment.
If it should be necessary to take legal action to collect the amount owed by you, the undersigned agrees to pay all costs and expenses of collection, including attorney's fees. I understand that I am responsible for all laboratory, radiology or other outside costs including pap smears, blood tests, pathology and cultures. I understand that if my insurance requires special handling or routing it is my responsibility to notify you before my exam or before going to the lab.

I HAVE READ AND UNDERSTAND THE ABOVE ______________________________
Signature Date

1941 Johnson Avenue. Ste. 202, *San Luis Obispo, Ca 93401* *Phone: (805) 548-0033* *Fax: (805) 548-0034*