Patient Profile

Your comfort and Privacy are very important to us

Patient Name: _____ Today's Date:_____

Date of Birth: _____/_____/_____ Age: _____ Gender: ____M____F

Mobile Phone Number: _____ Okay to Leave a Message? __Y ____N

Home Phone Number: _____ Okay to Leave a Message? ___Y ____N

Mailing Address

Street: _____

City: _____ State: _____ Zip: _____

Employer: _____

Work Phone Number: _____ Okay to Leave a Message? ____Y ____N

Email Address: _____

Would you like to be added to our newsletter email list? ____Y ____N

Name of your Primary Referring Physician: _____

Emergency Contact Person: _____ Phone #:_____

What is your primary concern that brought you to our office:_____

How did you hear about us?: _____

Primary Insurance Company: _____Policy/Group #_____

Policy Holder Name and DOB: _____

Secondary Insurance Company: _____Policy/Group #_____

Policy Holder Name and DOB: _____

*** Please provide us with your insurance card(s) so that we may keep a copy on file.**

Facial Beauty Policies

1. **We value your privacy and take every precaution with your information in order to assure you that your information is confidential.**
2. **While in our office, please do not use any electronic recording device(s).**
3. **Your comfort and safety are our foremost concern. If at any time, we may be of assistance, please let us know.**
4. **If applicable to you, Facial Beauty has your consent to release any medical information acquired in the course of your examination or treatment in order to process insurance on your behalf.**
5. **If appropriate, Facial Beauty agrees to process insurance claims on your behalf. Should insurance deny or pay only partially on a claim, it is understood that the balance will remain the responsibility of the patient and/or responsible party.**
6. **Facial Beauty has several innovative financing options available. Please ask us for more information if you are interested.**

By signing below, you acknowledge that you have provided accurate information and that you understand and agree to abide by Facial Beauty's Policies. Furthermore, you acknowledge that you have received a copy of the Privacy Policies for your records and you agree to be responsible for any financial arrangement(s) and/or balance(s) on your account.

Signature of Patient: _____Date:_____

If patient is a minor and/or there is another individual responsible for the financials, please fill out their name and have them sign below.

Name of Responsible Party: _____

Signature of Responsible Party: _____Date:_____