Name: _____ Date of Birth: _____

Age: _____ Male: _____ Female: _____ **Marital Status:** (circle one) M D S W

Home Phone: _____ Cell: _____ Email: _____@_____

Address: _____ City: _____ State: _____ Zip Code: _____

Employer: _____ Occupation: _____ Work Phone: _____

Address: _____

How did you hear about us? _____

Reason for your visit today? _____

Referring or Family Physician: _____ Phone: _____

Address: _____

Are you allergic to any Foods or Medications? Yes_____ What are you allergic to?_____

None _____

Name of Spouse, Parent or Guardian: _____

Date of Birth: _____ Employer: _____

Home Phone: _____ Work Phone: _____ Other Phone: _____Emergency Contact:

_____ Relationship: _____

Emergency Contact Cell Phone: _____ Emergency Contact Work Phone_____

Medical Release Information – Release of Information

Our office will make every effort to determine if your insurance benefits cover recommended treatments. However, *VERIFICATION OF BENEFITS BY OUR OFFICE IS NOT A GUARANTEE YOUR INSURANCE COMPANY WILL PAY BENEFITS. BENEFIT ELEGIBILITY IS DETERMINED AT THE TIME CLAIMS ARE SUBMITTED. FILING OF CLAIMS IS THE PATIENTS RESPONSIBILITY*.

I hereby grant permission to Dr. Jean Chapman to release any pertinent information to my insurance company or physician upon request including diagnosis and medical records relating to any treatment of examination rendered to me during the period that I am a patient at LaserMed. I further understand that I am financially responsible for any and all charges or professional services rendered at the time of service.

In connection with the use of the release and assignment, a Photostatic copy shall be considered as valid as the original.

Patient, Parent, Guardian Signature: _____ Date: _____