NAME: _____ **DOB:** _____

First Middle Initial Last

SS#: _____ **SEX:** _____ **MARITAL STATUS:** _____ **Race/Ethnicity:** _____

***If patient is a minor:**

Mother's Name: _____ Phone: _____ Employer: _____

Father's Name: _____ Phone: _____ Employer: _____

***If patient's spouse or parent is primary on insurance, please complete the following:**

PRIMARY INSURANCE Name of Insured: _____ Relationship to Patient: _____

DOB: _____ SS#: _____ Phone: _____

SECONDARY INSURANCE Name of Insured: _____ Relationship to Patient: _____

DOB: _____ SS#: _____ Phone: _____

ADDRESS: _____

STREET CITY STATE ZIP

HOME PHONE: _____ **CELL PHONE:** _____

OCCUPATION: _____ **WORK PHONE:** _____

EMAIL: _____

SPOUSE NAME: _____ **SPOUSE CELL PHONE:** _____

EMERGENCY CONTACT NOT IN HOUSEHOLD:

Name: _____ **Relationship to Patient:** _____

Phone: _____

Primary Physician: _____ **City, State** _____

Referring Physician: _____ **City, State** _____

PHARMACY: _____ **Location, City, State** _____

Do you have an Advanced Directive? Y N If yes, what type?

Do not resuscitate ____ **Living Will** ___ **Organ Donor** _____ **Power of Attorney** ___ **No Artificial Life Support** _____

I would like to receive periodic emails about cosmetic procedures and skin care products available at the office and the Aesthetic Skincare Center, including sales and special offers. Yes ___ **No** __