AESTHETIC EYE ASSOCIATES, PS DBA ALLURE LASER CENTER & MEDISPA

425-216-7200

(Please Print Legibly & Fill In or Correct All Fields)

Patient's Name ____
Last First Middle

Address ____
Street & Apt # City State Zip

Home Phone ____________ Cell Phone ______________ Work Phone ______________

Age ______ Birthdate ____/____/____ SS# ____-______-______ Sex Female Male

Marital Status Single Married to: __________________ Other __________________

Patient / Guardian Signature ______________________________ **Date** ____________

LEGAL GUARDIAN INFORMATION		
Last Name	First	MI
Home Phone ( )	Work Phone ( )	

REFERRING PHYSICIAN INFORMATION				
Last Name	First	MI	Address	Telephone ( )

EMERGENCY CONTACT INFORMATION		
Last Name	First	MI
Home Phone ( )	Work Phone ( )	

Patient's Employer ______________________ Occupation ______________________

Work Phone ____________ Ext: __________ Is it ok to call you at work? YES NO

Address ____
Street & Suite # City State Zip

Preferred Pharmacy ______________________________ Telephone ______________

PLEASE SEE BACK SIDE IF YOU WISH US TO BILL YOUR INSURANCE

PRIMARY INSURANCE COMPANY INFORMATION				
Primary Insurance Company Name	Identification Number		Group Number	
Primary Insurance Company Name	City	State	Zip	Telephone ( )
Policyholder *(if other that patient)*	Male Female		Date of Birth (of Policy Holder)	
Social Security Number *(of policyholder)*	Telephone *(of policyholder)* ( )		Relationship to Patient	
Employer *(of policyholder)*				

SECONDARY INSURANCE COMPANY INFORMATION				
Primary Insurance Company Name	Identification Number		Group Number	
Primary Insurance Company Name	City	State	Zip	Telephone ( )
Policyholder *(if other that patient)*	Male Female		Date of Birth (of Policy Holder)	
Social Security Number *(of policyholder)*	Telephone *(of policyholder)* ( )		Relationship to Patient	
Employer *(of policyholder)*				

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Insurance Related Visit: I authorize my insurance benefits to be paid directly to the doctor. I understand and accept that I am financially responsible for any balance due as directed by my insurance carrier. I authorize the doctor or insurance company to release any information required for the claim

Cosmetic Related Visit: I understand that all medispa and cosmetic services are payable in full on the day service is rendered. I understand these services will not be covered by my insurance company.

Signature ____ **Date** ___________________________

Reviewed by patient: ____ Date ______________________________

Reviewed by patient: ____ Date ______________________________

Reviewed by patient: ____ Date ______________________________