

**Patient's Name**

\_\_\_\_\_ First \_\_\_\_\_ Middle \_\_\_\_\_ Last \_\_\_\_\_

**Address**

\_\_\_\_\_ Street & Apt # \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Other Phone \_\_\_\_\_

Any restrictions for contacting you?  No  Yes E-mail \_\_\_\_\_

Contact Restrictions: \_\_\_\_\_

Age \_\_\_\_\_ Birthdate \_\_\_\_\_ SS# \_\_\_\_\_ Gender  Female  Male

Marital Status  Single  Married to: \_\_\_\_\_  Other: \_\_\_\_\_

**Patient's Employer**

\_\_\_\_\_ Occupation \_\_\_\_\_

Work Phone \_\_\_\_\_ Ext: \_\_\_\_\_ Is it okay to call you at work?  Yes  No

Address \_\_\_\_\_

\_\_\_\_\_ Street & Suite # \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

**Primary Doctor**

\_\_\_\_\_ Street Address \_\_\_\_\_ City \_\_\_\_\_ Phone \_\_\_\_\_

**How did you hear about Dr. Buinewicz?**

(Mark all that apply)

TV News  TV Ad  Phone Book  Magazine  Newsletter  Seminar  Salon  Web

Friend/Relative: \_\_\_\_\_  Doctor: \_\_\_\_\_  Other: \_\_\_\_\_

If you were referred by a specific person, may we thank them?  Yes  No

**Emergency Contact**

(Not in your household)

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Other Phone \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

**Primary Health Insurance Company**

Policy # \_\_\_\_\_ Group # \_\_\_\_\_ Ins. Phone \_\_\_\_\_

Referral Required?  No  Yes Copay?  No  Yes, \$ \_\_\_\_\_

Insured: Name \_\_\_\_\_ Insured DOB: \_\_\_\_\_ Employer \_\_\_\_\_

**Secondary Health Insurance Company**

Policy # \_\_\_\_\_ Group # \_\_\_\_\_ Ins. Phone \_\_\_\_\_

Referral Required?  No  Yes Copay?  No  Yes, \$ \_\_\_\_\_

Insured: Name \_\_\_\_\_ Insured DOB: \_\_\_\_\_ Employer \_\_\_\_\_

**Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

**Would you like a complimentary skin evaluation while you are here today?**  Yes  No