# Skin Care & Laser Physicians of Beverly Hills

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|---|---|---|---|
| Thank you for choosing our office. In order to serve you properly, PLEASE PRINT the following information. | | | |
| Name: | | | Date: |
| Address: | | City/State/Zip: , | |
| SSN: | Birthdate: | Marital Status: | Gender: |
| Home Ph: | Work Ph: | Cell Ph: | Other: |
| Fax: | Email: | | |
| Employer: | | | |
| Occupation: | | Full/Part/Student/Retired/Other: | |
| Emergency Contact: Tel: | | | Relationship: |
| Responsible Party: Tel: | | | |
| If patient is a child, who may authorize treatment:<br><br>Primary Care Physician: Tel: | | | Relationship: |

For office use only

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|---|---|
| I authorize this office to release to the named insurance company any information necessary to expedite insurance payment: I understand that I am responsible for all charges, regardless of insurance coverage. | |
| Patient, Parent or Guardian Signature: | Date: |