PATIENT INFORMATION - PLEASE PRINT

Patient's Name (First, MI, Last)	Birthdate	Age	Sex	Sgl.	Mar.	Div.	Wid.

Home Address	City	State	zip	Social Security #

Employer Name	Work Phone # ( ) (ext)	Cell Phone # ( )	Occupation

Home Phone # ( )	Ethnicity & Race:		
	☐ Hispanic/Latino	☐ Black/African American	☐ Other
Email Address	☐ Asian	☐ American Indian/Alaska Native	
	☐ White	☐ Native Hawaiin/Other Pacific Islander	

Name of Guardian or Primary Insured (Birthdate)	Relationship to Patient (circle one) Parent Spouse Grandparent Other

Address of Responsible Party - (if same as above write same)	Phone # ( )

Occupation of Guardian or Primary Insured	Social Security Number #	Work Phone # ( )

Employer of Guardian or Primary Insured	Address

Notify In Case of Emergency	Phone #

Referral Source:	Family Physician Dr.

PRIMARY INSURANCE COMPANY NAME	SUBSCRIBER	CERTIFICATE I.D. #	GROUP#

SECONDARY INSURANCE COMPANY NAME	SUBSCRIBER	CERTIFICATE ID #	GROUP#

It is your responsibility to verify whether or not our providers are participating with your Insurance plan. We encourage you to discuss fees prior to your examination to avoid any misunderstanding. Please contact your insurance company if you have any questions regarding covered services. In the event we are non-participating with your insurance plan, we will provide you with and itemized statement for you to send to your insurance to obtain reimbursement.

I give Dr. Aszterbaum permission to treat the above named patient. I understand I am financially responsible for all charges incurred and balance not paid directly by insurance company.

I authorize the release of any medical or other information necessary to process this claim.

Signed: _____ Date: _____ CA Driver's Lic. # _____

Please check off any that apply:

☐ Pacemaker/Defibrillator
☐ Metal Implants
☐ Diabetes
☐ Pregnant or Nursing
☐ History of Skin Cancer
☐ Disease stimulated by light or heat (e.g. cold sores, lupus)
☐ Abnormal wound healing (e.g. keloids)
☐ Permanent make-up or tattoo
☐ Use of medications that may cause photosensitivity (e.g. Accutane, Doxycycline)
☐ Hepatitis ☐ Blood Trans. ☐ HIV

List Allergies to Medication: _____

List Current Medications You Are Taking: _____