

Patient Registration

Please Print



Patient: _____
Last Name First Name Middle Initial

Address: _____
City State Zip

Email address: _____

Birth date: _____ Age: _____ Soc.Sec. #: _____ Sex: Male Female

Patient's Employer: _____ Patient's Occupation: _____

Marital Status: Single Married Widowed Separated Divorced

Spouse's Name: _____ Spouse's Soc.Sec. #: _____

Spouse's Employer: _____ Spouse's Occupation: _____

Mr. Miss Today's Date: _____
 Mrs. Ms. Preferred

Home Phone: () _____
Work Phone: () _____
Mobile Phone: () _____

Person Responsible for Bill - Insurance Guarantor

Patient's relationship to person responsible for bill: Self Spouse Child Dependent

Name: _____
Last Name First Name Middle Initial

Address: _____
Home Phone: () _____
Work Phone: () _____

Soc.Sec. #: _____

Insurance Information

Primary Insurance: _____ Secondary Insurance: _____
Please provide us with a copy of your insurance card and driver's license to verify your signature and date of birth.

Emergency Information and Release

In case of an emergency, local friend or relative to be notified (not living at same address):
Name: _____ Relationship to Patient: _____
Home Phone: () _____ Work Phone: () _____

Assignment and Release: I hereby authorize my insurance and government benefits be paid directly to the physician. I am financially responsible for any balance due. I also authorize the doctor or insurance company to release any information required for this claim. I am aware that I will be charged for appointments missed or cancelled without 24 hour notice.

Signature: _____

Were you referred to us by your doctor? <input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, Name and Address of Referring Physician _____ _____ Telephone: _____

May we contact you to remind you about upcoming or missed appointments? yes no
May we contact you regarding new services, products, and procedures? yes no
Would you prefer being contacted at home or at work?

We use an automated service to remind you of upcoming appointments.

Please continue on reverse

If you have any cosmetic interests, please check anything that may apply:

- | | |
|---------------------------------------------------------------------------------|-------------------------------------------------------------------|
| <input type="checkbox"/> BOTOX® treatment | <input type="checkbox"/> Micro-dermabrasion |
| <input type="checkbox"/> New types of filler injections
(restylane/sculptra) | <input type="checkbox"/> Spider vein treatments for face and legs |
| <input type="checkbox"/> Laser treatment for wrinkles | <input type="checkbox"/> Skin care advice |
| <input type="checkbox"/> Laser treatment for Brown Spots | <input type="checkbox"/> New Anti-aging Creams |
| <input type="checkbox"/> Laser treatment for Rosacea | <input type="checkbox"/> Laser treatment for acne scars |
| <input type="checkbox"/> Laser treatment for Tattoos | <input type="checkbox"/> Fat Cell Reduction |
| <input type="checkbox"/> Facial Skin Rejuvenation | <input type="checkbox"/> Laser treatment for Hair Removal |
| | <input type="checkbox"/> Hair Regrowth |

Please answer the following questions on a scale of 1 to 5 by circling the appropriate number:

When looking at my face in the mirror, I believe I look younger, the same as, or older than my true age.

Younger Than		True Age		Older Than
1	2	3	4	5

When looking in the mirror, I am not concerned, somewhat concerned, or very concerned about the appearance of my wrinkles.

Not Concerned		Somewhat Concerned		Very Concerned
1	2	3	4	5

How did you hear about us?

- My physician (full name) _____
- My insurance company provider _____
- The yellow pages (specific advertisement) _____
- A friend or family member (name) _____
- Another person not listed above (name) _____
- Our website (www.kirklandlaser.com) _____
- An article or advertisement in _____
- Radio _____