1030 E. Foothill Blvd., Ste. 101, Upland, CA 91786
P: 909.981.5859 F: 909.981.8293

PATIENT INFORMATION

Patient Name: _____
Last First Middle Initial

Age: ____ Birth Date: ____/____/____ Gender: M/ F Patient SS #: ____-___-_____ Marital Status: S/ M / Sep/ D/ W

Address: _____ Home Phone (_____)_____-_____ Cell Ph (_____)_____-_____
_____(city, state, zip) Work Ph (_____)_____-_____
Email address: _____

Employer: _____ Position: _____ Business Ph (_____)_____-_____

Person Responsible for Account: Self/ Spouse/ Father/ Mother/ Other: _____
_____ SS #: ____-___-_____
Last First Middle Initial

Spouse's Name: _____
Last First Middle Initial

Spouse's Employer: _____ Position: _____ Business Ph (_____)_____-_____

Referring Physician: _____ Referring Doctor's Phone: (_____)_____-_____

PRIMARY INSURANCE

Insurance Company: _____ Type: HMO / PPO / Other_____ Visit Copay: $_____

Policy ID #:_____ Group #:_____ Insurance Ph (_____)_____-_____

Policy Holder Name: _____
Last First Middle Initial

Relation to Patient: _____ Birth Date: ____/____/____ Gender: M / F

Policy Holder Address: _____
(If different from above) _____

Policy Holder's Home Phone (_____)_____-_____ Cell Ph (_____)_____-_____

Policy Holder's Employer: _____Position: _____

Employment Address: _____Business Ph (_____)_____-_____

EMERGENCY CONTACT INFORMATION

Contact Name: _____
Last First Middle Initial

Address: _____ Home Phone (_____)_____-_____ Cell Ph (_____)_____-_____
_____ Other Phone (_____)_____-_____ Work Ph (_____)_____-_____

PHARMACY NAME: _____ **ADDRESS:** _____
PHONE: _____ **FAX:** _____

ASSIGNMENT AND RELEASE

1. I am responsible for the balance of my account for any professional services rendered. I certify that this information is correct to the best of my knowledge. I will notify you of any changes at subsequent visits.
2. I authorize the release of any medical or other information necessary to process the insurance claims.
3. I authorize payment of medical benefits to the physician directly.
4. There is a $25.00 cancellation fee for missed office appointments. If an appointment is missed with no notification, the patient will be charged $25.00.

Responsible Party's Name_____ Responsible Party's Signature_____

Relationship_____ Responsible Party's Driver's License #: _____

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Tell us how you selected our office:
Welcome to our office!

□ Search Engine: Google / Bing / Yelp / Real Self
□ Magazine
□ www.inlandent.com
□ Social Media: Facebook / Instagram
□ Existing Patient Name: _____ *(information is confidential)*
□ Family Member or Friend who is not a patient
□ Physician, Name: _____
□ Other: _____

Interests:
Which of the following procedures interest you? (check all that apply):

□ Botox	□ Rhinoplasty (nose)	□ Chemical Peels
□ Fillers	□ Lip Augmentation	□ Microneedling
□ Chin Implant	□ Lip Lift	□ Skin Care Products
□ Cheek Implants	□ Eyelids Rejuvenation	□ Removal of Cysts/Moles
□ Face or Neck Lift	□ Protruding Ears	□ Laser Treatment
□ Forehead Lift	□ Facial Fat Grafting	□ Other: _____

Contacts:
May we contact you for upcoming events and promotions?

Email Address: _____

Cell phone no.: _____

When is the best time to call if we may? _____

Signature: _____ Date: _____