

Patient Information as of _____ (enter today's date)
(Please Print Legibly & Fill In or Correct All Fields)

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

How did you hear about Dr. Coolidge?

(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)

Relationship to Patient _____

Home Phone _____ Work Phone _____ Other Phone _____

Primary Health Insurance Company

Policy # _____ Group # _____ Ins. Phone _____

Referral Required? No Yes Copay? No Yes, _____

Insured: Name _____ DOB _____ Employer _____

Secondary Health Insurance Company

Policy # _____ Group # _____ Ins. Phone _____

Referral Required? No Yes Copay? No Yes, _____

Insured: Name _____ DOB _____ Employer _____

I understand that office visit charges are payable on the day service is rendered. I authorize Dr. Coolidge to bill my insurance company for medically necessary services. Regardless of insurance coverage, I am responsible for all bills being paid in a timely manner. I understand that my contract is between Dr. Coolidge and myself.

Signature _____ Date _____

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