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: ,	
	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: Primary Care Physician: Tel:			Relationship:

For office use only

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: