

(Please Print Clearly)

Name: \_\_\_\_\_ Nickname: \_\_\_\_\_  
(last) (First) (M.I.)

Address: \_\_\_\_\_ Apt/unit#: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_\_ M / F Marital Status: Single / divorced / Married / Other

Home #: (\_\_\_\_) \_\_\_\_\_ Cell #: (\_\_\_\_) \_\_\_\_\_ Work #: (\_\_\_\_) \_\_\_\_\_ Preference: H / C / W

Please express any contact restrictions: \_\_\_\_\_

E-Mail Address: \_\_\_\_\_ OK to use? Y / N

Spouse / SO Name: \_\_\_\_\_ Contact #: (\_\_\_\_) \_\_\_\_\_

Employer: \_\_\_\_\_

**Insurance information (Please provide a card):**

Primary card holder: \_\_\_\_\_ Member ID #: \_\_\_\_\_

*Please note that we **do not** bill your insurance company on your behalf, but will provide you with the billing information for you to self-bill.*

**IN CASE OF EMERGENCY WE REQUIRE A PERSON OTHER THAN A SPOUSE AND TWO (2) CONTACT NUMBERS**

Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_

Primary contact #: (\_\_\_\_) \_\_\_\_\_ Secondary Contact #: (\_\_\_\_) \_\_\_\_\_

**Please tell us how you discovered our practice:**

Friend \_\_\_\_ Family Member \_\_\_\_ Internet \_\_\_\_ website \_\_\_\_ yellow pages \_\_\_\_ Seminar \_\_\_\_ Other \_\_\_\_

Please share the name of your friend/family referral: \_\_\_\_\_ May we thank him/her? Y / N

***The above information is true and accurate to the best of my knowledge. I understand that I am financially responsible for any fees at the time of service; unless other arrangements have been approved. I authorize Cascade Medical Aesthetics to release any information required to my insurance company in an attempt to justify a claim.***

Client / Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_