David L. Allyn, MD

Aesthetic Dermatology
LASER & COSMETIC SURGERY
SPA & SALON

Patient Information Registration

Last Name	First Name	Middle Initial

Date of Birth	Age	Gender ☐Male ☐Female	Social Security Number

If Minor, Parent's Name	Relationship to Patient	Primary Language

Address

Street	City/State	Zip Code

Patient Contact Information

Home	Mobile/Cell	Work

E-mail Address: ☐Personal ☐Business	Alternate E-mail Address: ☐Personal ☐Business

Preferred Method of Contact:	☐Phone OR ☐US Mail (Please provide alternate contact number and/or mailing address, if any)

Required Government Documentation

Student Status:	**Marital Status:**	**Race:**	**Ethnicity:**
☐Full Time ☐Part Time	☐Single ☐Married ☐Widowed ☐Divorced	☐American Indian or Alaska Native ☐Asian ☐Black/ African American ☐More Than One Race ☐Native Hawaiian/ Other Pacific Islander ☐White ☐I choose not to specify	☐Hispanic or Latino ☐**Not** Hispanic or Latino ☐I choose not to specify
Employment Status: ☐Full Time ☐Part Time ☐Retired ☐Self Employed	Spouse's Name: Spouse's Employer and Phone Number:		

Occupation:	**Name of Employer:**

Insurance Information

Primary Insurance Company Name		Secondary Insurance Company Name	
ID Number	Group Number	ID Number	Group Number
Name of Policy Holder		Name of Policy Holder	
Date of Birth of Holder	Social Security Number of Holder	Date of Birth of Holder	Social Security Number of Holder
Insured's Name (if different from Policy Holder)		Insured's Name (if different from Policy Holder)	

Authorization to Release Medical Information and Emergency Contact Person

I herein give my permission for Aesthetic Dermatology, P.A. to disclose any pertinent information regarding my medical records to the person(s) listed below to ensure my continuity of care. I hereby release Aesthetic Dermatology, P.A. from any and all liability which may result from the use of any such information. In case of emergency, I give my permission to contact the designated name(s) below.

Name(s) of Authorized Person(s) and Phone Number:	Relationship to Patient (Check box if person is an **Emergency Contact**)
1.	☐
2.	☐
3.	☐

Patient Signature (Parent or Legal Guardian, if minor): _____

Print Name: _____ Date: _____