Glasgold Group Patient Information as of _____(today's date)

NAME:				
	LAST	**FIRST no nicknames please**		**MIDDLE INITIAL**
ADDRESS:				
	STREET & APT	**CITY OR TOWN**	**STATE**	**ZIP CODE**

PHONE NUMBERS

CELL#( )	**WORK#( )**	**HOME#( )**
E-MAIL:	**Would you like to receive offers ❒ yes ❒ no**	
Date of Birth:	**Age:**	**Social Security#**

❒married ❒single ❒other ❒under 18

If patient is a minor (under 18) do we have permission to treat the child?

Authorized Signature: **Today's Date:**

Relationship to child:

How were you referred to us, check box ❒Website ❒newspaper ❒ salon ❒patient ❒ doctor ❒other

Name of referral source:

Patient Employer Information	
	Employer **Occupation**

Emergency contact information

Name: **relationship to patient:**

Phone/Cell# **e-mail:**

Primary Health Ins Co:	**ID#**	**Group#**
Subscriber Name:	Subscriber date of birth:	
Subscriber Employer:	Relationship to patient:	
Subscriber address if different from above		

IF YOU ARE HERE DUE TO A WORK RELATED INJURY OR AUTO ACCIDENT PLEASE INFORM THE FRONT DESK SO THAT THEY MAY GIVE YOU THE APPROPRIATE FORMS TO FILL OUT.

I understand payment is due the day service is rendered.

Signature of Responsible Party:

I authorize the Glasgold Group to bill my insurance company. I authorize the release of any information required to process my claim to my insurance company.

I understand that The Glasgold Group is an **out of network** provider. I understand I am responsible for payment. I understand that this contract is between the Glasgold Group and myself. I hereby authorize payment directly to the doctor. I understand that if payment is sent to me in error for procedures I have not paid for, that I must surrender the check and EOB(explanation of benefits)to the Glasgold Group. I understand that this is **not reimbursement for any cosmetic fee(s)** paid to the doctor. My signature below is an acknowlegment and acceptance of the the above statements.

Signature of responsible party:	**Date**	