

Kaysville Clinic and Ohana Skin Rejuvenation and Laser Center

Patient

Patient First Name		Middle Initial	Last name		Name Goes By:
Patient Street Address			City	State	Zip Code
Mailing Address (Use only if different than physical address)			City	State	Zip Code
Patient Date of Birth	Patient Social Security Number		Patient Email Address		<input type="checkbox"/> Male <input type="checkbox"/> Female
Home Phone	Other Phone	Spouse's Name	Patient Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed		
Emergency Contact Name		Emergency Contact Phone	Relationship to Patient		
Patient's Employer		Employer's Phone	Employer's Address		
Father's Name (If patient is a minor)		Mother's Name (If patient is a minor)	Who Does Patient Live With (If patient is a minor)		

Responsible Party Information

Responsible Party's First Name		Middle Initial	Last Name		Patient's Relationship to Responsible Party
Street Address			City	State	Zip Code
Date of Birth		Social Security Number		<input type="checkbox"/> Male <input type="checkbox"/> Female	
Spouse's Name	Home Phone	Other Phone	Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed		
Employer		Employer Phone	Employer Address		

Insurance (provide your insurance card to the front desk at check-in)

Primary Insurance Company		Policy #	Group #	
Policy Holder		Date of Birth	Soc. Sec #	Marital Status
Policy Holder Address		City	State	Zip Code
Policy Holder Phone #		Other Phone	Patient Relationship to Policy Holder	
Secondary Insurance Company		Policy #	Group #	
Policy Holder		Date of Birth	Soc. Sec #	Marital Status
Policy Holder Address		City	State	Zip Code
Policy Holder Phone #		Other Phone	Patient Relationship to Policy Holder	

Self Pay/No Insurance

How did you hear about Kaysville Clinic or who was it that referred you to our office today? _____

I represent and affirm that the above information is true and correct and it is my understanding that this office is relying on the above information that I have provided. I hereby give permission to Kaysville Clinic and Associates to administer treatment as may be deemed necessary in the diagnosis and treatment of my medical condition(s).

Signature of Patient or Parent/Guardian/Authorized Representative

Date

Printed Name of Signature Above

Relationship to Patient