REHLEN, BARTLOW, GOODMAN & BARON,
PASSERO PA-C, SAEDLER PA-C, PARSA PA-C
LENNERTZ PA-C, COTTRELL PA-C, WONG -ESTHETICIAN

PATIENT INTRODUCTION DATE: ________________

HOME PHONE: (____)________________________ BIRTHDATE:__________________

CELL PHONE (_____) ___________________ **EMAIL: ____________________________________**

PATIENT ____AGE:_________ Male ____ Female ____
FIRST MIDDLE MAIDEN LAST

MAILING ADDRESS ____
STREET CITY STATE ZIP

SOCIAL SECURITY # ___________________________ OCCUPATION: ________________________

NAME OF PERSON LEGALLY RESPONSIBLE
(If patient is a minor, name of parent, guardian, etc.) ____

SOCIAL SECURITY # ____________________________________ DATE OF BIRTH_________________

EMPLOYED BY ______________________________ **WORK PHONE** (________)_____________________

BUSINESS ADDRESS ____
STREET CITY STATE ZIP

NAME OF SPOUSE ______________________________________DATE OF BIRTH _________________
FIRST MIDDLE LAST

SOCIAL SECURITY # ____________________________________OCCUPATION____________________

SPOUSE EMPLOYED BY __________________________________ WORK PHONE (______)___________

BUSINESS ADDRESS ____
STREET CITY STATE ZIP

CONTACT (In case of emergency) ____(_______)_____________
FULL NAME ADDRESS PHONE

PRIMARY INSURANCE

Insurance Company _________________________ ID#____________________
Group #/Employer # ____
Phone # __________________________ Name of subscriber? _____________________
Is this an Individual Policy _________________ or Employer Policy _________________

SECONDARY INSURANCE

Insurance Company _________________________ ID#____________________
Group #/Employer # ____
Phone # (______)______________________ Are you the subscriber? __________________
Is this an Individual Policy _________________ or Employer Policy _________________

REFERRED BY X____(_____)__________
FULL NAME ADDRESS PHONE

AUTHORIZATION FOR MEDICAL TREATMENT, RELEASE OF MEDICAL INFORMATION TO INSURANCE COMPANY AND ASSIGNMENT OF BENEFITS

I/We do hereby consent to and authorize the performance of all treatments, surgery and medical services by the physicians and staff, which they may deem advisable. I also hereby assign, authorize, and/or allow payment of benefits directly to Rehlen, Bartlow, Goodman & Baron for the medical benefits otherwise payable to me for services described. I authorize Rehlen, Bartlow, Goodman & Baron to release any information acquired in the course of my examination or treatment to my insurance company or provider rendering care. I also authorize any provider to release to Rehlen, Bartlow, Goodman & Baron any information including diagnosis and records of treatment or examination rendered to me during the period from ________________ to _______________.

X______________________________________
Signature of Patient/Parent/Guardian

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