

**Aistheta Reno Medical Skin Care Center**

6630 S. McCarran Blvd., Ste. A-9

Reno, NV 89509

Ph: 775-829-1212 – Fax: 775-829-1179

DATE: \_\_\_\_\_

**PATIENT INFORMATION**

**Patient Name:** \_\_\_\_\_  
(last) (first) (middle)

**Physical Address:** \_\_\_\_\_  
(street) (city, state) (zip)

**Mailing Address:** \_\_\_\_\_  
(street) (city, state) (zip)

**Home Phone:** (\_\_\_\_) \_\_\_\_\_ **Work Phone:** (\_\_\_\_) \_\_\_\_\_ **Cell Phone:** \_\_\_\_\_

**Birth date:** \_\_\_\_\_ **Social Security Number:** \_\_\_\_\_ **Sex:** F M **Marital Status:** S M D W

**If a Minor, Parents' Names:** \_\_\_\_\_  
(mother) (father)

**Emergency Contact:** \_\_\_\_\_  
(name) (home phone) (cell phone) (work phone) (relationship)

**Preferred Contact Method:** \_\_\_\_\_ **E-Mail Address:** \_\_\_\_\_

**How did you hear about us:** \_\_\_\_\_

**EMPLOYMENT INFORMATION - PATIENT**

**Occupation:** \_\_\_\_\_ **Work Phone:** \_\_\_\_\_

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

**Employer Address:** \_\_\_\_\_  
(street) (city, state) (zip)

**SPOUSE/PARENT**

**Spouse/Parent's Name:** \_\_\_\_\_ **Occupation:** \_\_\_\_\_

**Employer:** \_\_\_\_\_ **Work Phone:** (\_\_\_\_) \_\_\_\_\_

**INSURANCE INFORMATION**

**PRIMARY INSURANCE**

**Name of Subscriber:** \_\_\_\_\_ **Relationship to Patient:** \_\_\_\_\_

**Birth date of subscriber:** \_\_\_\_\_ **Social Security Number:** \_\_\_\_\_

**Employer:** \_\_\_\_\_ **Work Phone:** (\_\_\_\_) \_\_\_\_\_

**Employer Address:** \_\_\_\_\_  
(street) (city, state) (zip)

**Insurance Company:** \_\_\_\_\_ **Policy Number:** \_\_\_\_\_ **Group Number:** \_\_\_\_\_

**SECONDARY INSURANCE**

**Name of Subscriber:** \_\_\_\_\_ **Relationship to Patient:** \_\_\_\_\_

**Birth date of subscriber:** \_\_\_\_\_ **Social Security Number:** \_\_\_\_\_

**Employer:** \_\_\_\_\_ **Work Phone:** (\_\_\_\_) \_\_\_\_\_

**Employer Address:** \_\_\_\_\_  
(street) (city, state) (zip)

**Insurance Company:** \_\_\_\_\_ **Policy Number:** \_\_\_\_\_ **Group Number:** \_\_\_\_\_

I am consenting to be treated. By agreeing to receive care, you are consenting generally to other medical treatments such as laboratory test and minor procedures that your physician may order. I understand that co-payments are due at time of visit. I authorize release of any medical information necessary to process my medical claim. I realize that I am responsible for any balance my insurance company does not pay/cover.

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

I have no insurance and agree to pay my balance in full at each visit.

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_