PATIENT INFORMATION Patient No.________________ Date: ______________

The following information is very important to your health. Please take the time to fully and accurately fill out this form.

Confidential Record: The information below will not be released except when you have authorized us to do so.

Last Name	First Name	Middle	Birth Date	Age	Height	Weight

Address (**PLEASE NO P.O. BOX NUMBERS**)	City/State	Zip Code	(area code) Home No.	(area code) Cell Phone

Occupation	(area code)) Work Phone	Social Security Number	Male	Female	Marital Status

Primary Insurance Company	Primary Insurance ID Number	Primary Group Number
Secondary Insurance Company	Secondary Insurance ID Number	Secondary Group Number

Email address (Please print clearly)____

Person to notify in case of an emergency________________________________ Relationship________________

Emergency contact telephone number: ________________________

Primary Care Doctor (please include first name)____

Date of last physical exam______________ How were you referred to our office? _________________________

HAVE YOU HAD: (Please check all that apply)

AIDS/AIDS Related Illness______ Arthritis______ Asthma______ Back Pain______ Cancer______ Congenital Heart ______

Diabetes______ Depression/Psychiatric Treatment______ Easy Bruising______ Fainting______ Hay Fever ______

Heart Attack/Chest Pain______ Heart Murmur______ Hepatitis______ High Blood Pressure______ Kidney Disease______

Migraine______ Nervous Breakdown______ Persistent Cough______ Phlebitis (clot in leg)______ Rheumatic Fever______

Stomach Ulcers______ Stroke Seizures______ Tuberculosis______

PERSONAL HABITS: (CIRCLE)

YES NO Do you regularly smoke?____ Pipe ___ Cigarettes Packs Per Day____ For How Long?____ Date Quit_______

YES NO Do you usually drink more than 6 cups of coffee per day?

YES NO Do you regularly drink alcohol?____ How many drinks per day? ___________

YES NO Do you have dentures or bridges?

YES NO Are your front teeth capped?

YES NO Are any teeth loose, chipped or bad?

YES NO Do you wear contact lenses?

YES NO Do you take aspirin, vitamin K or vitamin E? How many?_________

LIST ALL MEDICATION PRESENTLY TAKING: (Please list over-the-counter medication - i.e., vitamins)

Name any drugs you are allergic to:

____

List the names and dates of any operations you have had (include plastic surgery procedures), and major dental surgery.

____

____

Have you or your relatives had an unexplained or serious complication during surgery or anesthesia?

____

____

Have you ever had a blood transfusion? __________ When?____

To be answered by WOMEN only: (CIRCLE)

YES NO Are you still having regular monthly menstrual periods?

YES NO Are you now on or have you ever taken the birth control pill? When? ____

How many children? ____________________ How many miscarriages? ____

How many cesarean operations?____________________ Any complication of pregnancy?______________________________________

Date of last menstrual period______________________ Is it possible you may be pregnant? ____________________________________

BILLING INFORMATION

FINANCIALLY RESPONSIBLE PERSON Patient Spouse Parent Other _____________________	NAME (if different from patient/insured)	HOME PHONE
FINANCIALLY RESPONSIBLE PERSON'S ADDRESS (IF DIFFERENT FROM PATIENT)		
FINANCIALLY RESPONSIBLE PERSON'S EMPLOYER	EMPLOYER ADDRESS	WORK PHONE

****If for any reason a return credit must be issued, a 7% processing fee will be deducted from the total amount refunded.**
All skin care products are non-refundable.

There is a $25.00 fee for any returned check

The undersigned agrees to promptly pay all charges when billed for medical services rendered and the person's listed below agree and do hereby become legally responsible for any and all charges incurred for the patient referred to above. **X**
____

The above is true and correct to the best of my belief.

All accounts are due within 60 days from the initial date of treatment. Any account over 60 days may be subject to a service charge of 1.5%/month. In the event of non-payment, you will be responsible for all costs of collection, including attorney's fees.

PATIENT INSURANCE AUTHORIZATION

I, ____, hereby authorize Stephen R. Kay, M.D, F.A.C.S. to apply for benefits for covered services. I request payment from my insurance company be made directly to the above-named physician. I agree to pay for all services that are not covered by my insurance.

I certify that I have read and understand all the above information. The information I have reported with regard to my insurance coverage is correct and further authorize the release of any necessary information, including medical information for this or any related claim to the above-named carrier. I permit a copy of this authorization to be used in place of the original. Either the above-named carrier or I may revoke this authorization at any time in writing.

X____
____
Signature of Subscriber, Beneficiary, or Responsible Party Date