CHRYSALIS COSMETICS

916.273.7435

Patient Information as of _____ (enter today's date)
(Please Print Legibly & Fill In or Correct All Fields)

Patient's Name _____
Last First Middle

Address _____
Street & Apt # City State Zip

Home Phone _____ Cell Phone _____ Other Phone _____

Any restrictions for contacting you? ❒ No ❒ Yes E-mail _____

Contact Restrictions: _____ Drivers License # (include State) _____

Age _____ Birthdate ___/___/___ SS# ___-___-___ Sex ❒ Female ❒ Male

Marital Status ❒ Single ❒ Married to: _____ ❒ Other: _____

Patient's Employer _____ Occupation _____

Work Phone _____ Ext: _____ Is it okay to call you at work? ❒ Yes ❒ No

Address _____
Street & Suite # City State Zip

Emergency Contact

Name: _____ Relationship to Patient _____

Cell Phone _____ Home Phone _____ Work Phone _____

Address _____
Street & Apt # City State Zip

I understand that office visit charges are payable on the day service is rendered. I authorize Dr. Perry to bill my insurance company. Regardless of insurance coverage, I am responsible for all bills being paid in a timely manner. I understand that my contract is between Dr. Perry and myself.

Signature _____ **Date** _____

By initialing below, you acknowledge that a copy of our Notice of Privacy Practies has been provided to you, that you understand the contents and how it applies to you, and that all of your questions regarding the contents have been answered.

Initials _____