

MICHAEL H. COVERMAN, M.D.
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TAMMY HUNT, LA, LT
CHRISTI GONZALES, LA, LT
www.laserskin.com

Date:

Chart #:

PATIENT INFORMATION

Last Name _____ First Name _____ M.I. _____ Nickname _____
Address _____ Apt # _____
City _____ State _____ Zip _____
Home Phone (____) _____ - _____ Work Phone (____) _____ - _____ Cell Phone (____) _____ - _____
Birthdate ____/____/____ Sex _____ Age _____ Marital Status: S M D
Employer/School Name _____ Employed: Full/ Part Time Student: Full/Part Time
Employer/School Address _____ City _____ State _____ Zip _____
Phone (____) _____ - _____ Current Driver's License # _____ State _____
Are other family members seen here? _____ Names? _____

EMERGENCY CONTACT

Name _____ Phone (____) _____ - _____ Hm Wk Cell Relationship _____

REFERRED BY

Doctor Friend Medical Society Yellow Pages Website Newspaper TV
Other _____ Please list the referral source _____

PRIMARY INSURANCE (complete blanks below with insured's information)

Insured's Name _____
Sex _____ Birthdate ____/____/____
Patient's Relationship to Insured _____
Employer _____
Employer's Address _____
City _____ State _____ Zip _____
Insurance Co Name _____
Phone (____) _____ - _____ COBRA Policy? Y N
ID# _____ Group # _____

SECONDARY INSURANCE (complete with insured's information)

Insured's Name _____
Sex _____ Birthdate ____/____/____
Patient's Relationship to Insured _____
Employer _____
Employer's Address _____
City _____ State _____ Zip _____
Insurance Co Name _____
Phone (____) _____ - _____ COBRA Policy? Y N
ID# _____ Group # _____

GUARANTOR or INSURED (if other than patient)

Last Name _____ First Name _____ M.I. _____ Sex _____
Address _____ City _____ State _____ Zip _____
Home Phone (____) _____ - _____ Work Phone (____) _____ - _____ Cell Phone (____) _____ - _____
Birthdate ____/____/____ Age _____ Relationship to patient _____

Patients or Authorized Person's Signature:

I authorize release of any medical or other information necessary to process this claim.

Signed _____ Date _____

I authorize payment of medical benefits to the undersigned physician described below.

Signed _____ Date _____

I give permission to call the phone number listed below (voicemail included) for lab results or appointment reminders.

Phone number _____ Signed _____ Date _____

I hereby agree to allow Dr. Coverman, Jennifer Jordan, MS, PA-C and/or his staff, under his supervision, to give me medical care according to today's standards. This consent also applies to any minors or dependents in my care, and applies to this and all subsequent future visits (whether I accompany the dependent or not).

Signed _____ Date _____

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