PLEASE COMPLETE ALL INFORMATION

PATIENT'S NAME ____ DOB______________AGE__________
LAST FIRST M.I.

ADDRESS___________________________________ ___________________________ __________ ____________
STREET CITY STATE ZIP

HOME PHONE(______)__________________________

WORK PHONE (______)_____________________________

CELL PHONE (______)_________________________

EMAIL______________________________________

SOCIAL SECURITY NUMBER____________________________

OCCUPATION____

EMPLOYER____

ADDRESS___________________________________ ____________________________ ______ ____________
STREET CITY STATE ZIP

SPOUSE NAME____

REFERRED BY____

REASON FOR OFFICE VISIT____

DO YOU HAVE INTEREST IN LEARNING ABOUT SKINCARE TREATMENTS AND/OR PRODUCTS? YES NO

RELEASE AND ASSIGNMENT: I understand that office visit charges are payable on the day service is rendered. I hereby authorize Dr. James Wade to release any information including diagnosis and records of any treatment or examination rendered to me during such medical care to any practice or physician involved in my care.

NAME ____ DATE ________________________________