LaserMed Skin and Vein Specialists
2880 Old Alabama Road, Suite 300
Johns Creek, GA 30022

Name: _____ SS#: _____ Date of Birth: _____

Age: _____ Male: _____ Female: _____ Marital Status: (circle one) M D S W

Home Phone: _____ Mobile Phone: _____ Email: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Employer:_____ Occupation: _____ Work Phone: _____

Address: _____

How did you hear about us?: _____

Reason for your visit today? _____

Referring or Family Physician: _____ Phone: _____

Address: _____

Allergies: _____ Drug Allergies: _____

Name of Spouse, Parent or Guardian: _____

Date of Birth: _____ SS#: _____ Employer: _____

Home Phone: _____ Work Phone: _____ Other Phone: _____

Emergency Contact: _____ Relationship: _____

Emergency Contact Home Phone: _____

Emergency Contact Work Phone: _____

Emergency Contact Other Phone: _____

Medical Release Information – Release of Information

Our office will make every effort to determine if your insurance benefits cover recommended treatments. However, *VERIFICATION OF BENEFITS BY OUR OFFICE IS NOT A GUARANTEE YOUR INSURANCE COMPANY WILL PAY BENEFITS. BENEFIT ELEGIBILITY IS DETERMINED AT THE TIME CLAIMS ARE SUBMITTED. FILING OF CLAIMS IS THE PATIENTS RESPONSIBILITY*.

I hereby grant permission to Dr. Jean Chapman to release any pertinent information to my insurance company or physician upon request including diagnosis and medical records relating to any treatment of examination rendered to me during the period that I am a patient at LaserMed. I further understand that I am financially responsible for any and all charges or professional services rendered at the time of service.

In connection with the use of the release and assignment, a photostatic copy shall be considered as valid as the original.

Patient, Parent, Guardian Signature:_____ **Date:**_____