COOLEY
HAIR CENTER

How did you find us?

❑ Family/Friend - Name:_____
❑ Insurance Provider List
❑ Internet Search
❑ Physician - Name:_____
❑ Yellow Pages
❑ Other_____

PATIENT INFORMATION

Last Name: _____ ❑ Male ❑ Female

First Name: _____ MI: _____

DOB:_____Social Security #:_____

Mailing Address: _____
(if PO Box, complete Home Address below)

City: _____ State: _____ Zip Code: _____

Home Phone: (_____)_____ Cell Phone: (_____)_____

Primary Physician:_____

Physician Phone Number: (_____)_____

Employer:_____

Employer Address:_____

Work Phone: (_____)_____ Ext: _____

Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Legally Separated ❑ Partner

Student Status: ❑ Full-Time ❑ Part-Time ❑ Not a student

Responsible Party, if different from patient information above:
(statements will be addressed to the responsible party)

Name: _____

Address: _____

City: _____ State:_____ Zip:_____

Employer Name: _____

Date of Birth: _____ ❑ Male ❑ Female

Social Security Number:_____

Phone: (_____)_____ Email: _____

Relationship to patient: _____

Adult Emergency Contact:

Name: _____

Address: _____

City: _____

State: _____ Zip Code: _____

Phone: (_____)_____ Alt. Phone: (_____)_____

Relationship to patient: _____

INSURANCE INFORMATION: If the patient is not the primary policy holder, the Responsible Party section above must be completed.

❑ Self Pay *(no insurance)* ❑ Patient IS the policy holder ❑ Patient IS NOT the policy holder

Primary Insurance Co.: _____ Policy Number: _____

Secondary Insurance Co.: _____ Policy Number: _____

Does your insurance plan require you to have a referral to see a specialist? ❑ No ❑ Yes ❑ I don't know
NOTE: It is the patient's responsibility to get any required referrals. Failure to do so may result in denied claims and the patient will be responsible for all services rendered.

HOME ADDRESS (REQUIRED if PO Box is given as mailing address):

Address: _____

City: _____

State: _____ Zip Code: _____

PHARMACY INFORMATION:

Name: _____

Location: _____

Phone: _____

By signing below, I authorize Cooley Hair Center to leave messages in reference to any items that assist in carrying out healthcare operations.

Home Phone: ❑ No Work Phone: ❑ No Email: ❑ No - or list the Email address to use: _____

Please list any persons to whom your protected health information can be disclosed (e.g., spouse, parent, etc.):

Name: _____ Phone Number(s): _____ Relationship: _____

Name: _____ Phone Number(s): _____ Relationship: _____

Patient or Responsible Party **Signature**: _____ Date: _____