MEDISPA MAUI
1445 South Kihei Road, Kihei HI 96753
Phone (808) 879-4909 Fax: (808) 879-4933

Thank You for choosing our office to assist in caring for your skin.
In order to serve you properly we request the following information. *PLEASE PRINT. All* ***information will be kept confidential.***

Patient's Name:	Birthdate:	M F	Email: Ok to send emails: Y N
Part Time Resident: Y N	Marital Status:	Home Phone:	Cell Phone:

Mailing Address: Ok to send mail: Yes No	Apt#	City	State	Zip
Mainland Mailing Address:	Apt#	City	State	Zip

Name of Employer:	Employer Address:	Employer Phone:
Occupation:	Whom Should We Thank For Referring You?	May we leave messages at your home? May we leave messages on your cell?

IF PATIENT IS A MINOR, PLEASE FILL OUT SECTION 2, OTHERWISE SKIP TO SECTION 3

Mother's Name:	Street Address/City/State/Zip:		Home Phone:
Mother's Employer:	Occupation:	How Long Employed:	Work Phone:

Employer Address:	Suite #	City	State	Zip

Father's Name:	Street Address/City/State/Zip:		Home Phone:
Father's Employer:	Occupation:	How Long Employed:	Work Phone:

Employer Address:	Suite #	City	State	Zip

INSURANCE INFORMATION (Applicable to some cosmetic appointments, ask for details if desired)

Do you have medical insurance?	If No, How do you intend to Pay for your medical visit? Cash Check CC: Visa MC Amex Disc

Insurance Company:	Address:	City	State	Zip

Subscriber: Self Other: Name: ___________________________ Birthdate:______________ Phone #:__________________

Policy Name/Type:	Policy #	Person Financially Responsible for this Account: Self Other:___________________________

Emergency Contact:	Relationship:	Address:	Phone:
If Patient is a minor, who authorizes treatment?	Relationship	Address:	Phone:

Do you authorize release of your medical information
to anyone other than your insurance company? No Yes If Yes, Whom?

I understand that I am responsible for all charges regardless of insurance coverage. By signing this section I authorize payment of benefits provided by the group plan directly to Brian Stolley MD, INC

Patient, Parent or Guardian Print: ______________________________ Date: ________________

Signature: ______________________________

***PLEASE PRESENT INSURANCE CARD & PHOTO ID TO RECEPTIONIST UPON COMPLETION OF INTAKE PAPERWORK**

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