INTRO PAID: ____________ ROF: ____________

Contour Red Light Patient Information

600 N. Western Ave.
Sioux Falls, SD 57104
(605)-332-1962

Date: ________________

First Name ________ **M.I** ________ **Last Name** ________

Social Security # (Required) ________ ☐ **Male** ☐ **Female**

Employer ________ **Occupation** ________ **Phone** ________

Spouse Name ________ **Phone** ________

Emergency Contact ________ **Phone** ________ **Relationship** ________

Primary Physician ________ **Phone** ________

CONFIDENTIAL HEALTH INFORMATION

Acknowledgements

Please read each statement below and initial your agreement

Initial _____ I acknowledge any quote of insurance payment is NOT a guarantee of payment. I acknowledge that any insurance I may have is an agreement between the carrier and me and that I am responsible for the payment of any covered or non-covered services I receive.

Initial _____ I have read and reviewed the Privacy Policy and understand it describes how my personal health information is protected and released on my behalf for seeking reimbursement from any involved third parties.

Initial _____ I grant permission to be called to confirm or reschedule an appointment and to be sent occasional cards, letters, emails, or health information to me as an extension of my care in the office.

Initial _____ I realize that an X-ray examination may be hazardous to an unborn child and I certify that to the best of my knowledge I am not pregnant.

To the best of my ability, the information I have supplied is complete and truthful. I have not misrepresented the presence, severity or cause of my health concern.

____

Signature of Patient or Parent of patient if a minor