Aleksandr Benji FNP
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(646) 301-4000

PATIENT INTAKE FORM
(Please print)

Name_____ Phone_____

Age_____ Ht. _____ Wt. _____

Address_____

City/State_____ Zip Code_____

Email Address: _____

In Case of Emergency:

Name:_____ Relationship: _____ Phone:_____

HOW DID YOU FIND US? ____ Internet _____ Sign _____ Car Sign _____ Business card

Referred by: _____

MEDICATIONS: _____

ALLERGIES: _____

Physician's Name_____ Tel # _____

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been answered accurately. I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance of my account for any professional services rendered. I authorize payment to Aesthetic Solutions NY, when assignment has been taken. I have read and agree to the office financial policy and agree to all terms and conditions and revisions of those terms and conditions. I authorize Aesthetic Solutions NY, to use or disclose any information for treatment, payment and health care operations. I authorize that the physician/nurse practitioner and/or employees of Aesthetic Solutions NY can contact me via all electronic formats (such as telephone, e-mail, fax, etc) or leave me a message if they are unable to contact me directly. I have read or received a copy of the Notice of Privacy Practices.

Patient Name: _____ Date: _____