Center for Age Management

Andrea Cole D.O.
561 Saxony Place, Suite 101
Encinitas, CA 92024

Last Name:______________________________First Name:________________________M.I.________

Address:________________________________City, State & Zip:______________________________

Alternate Address:______________________City, State & Zip:_______________________________

Home Phone:_______________Cell Phone:__________________Work Phone:__________________

Date of Birth:____/___/______Social Security Number:__________________________________

E-Mail Address:______________________________________@_________________________________

Occupation:_____________________________Employer:______________________________________

Spouse's Name:____________________________ Phone Number:___________________________

Emergency Contact Name:___________________________Relationship:_____________________

Phone Number:_______________________________**Referred By:**____________________________

Payment is required in full for each visit. We will gladly provide you with coding information that you may submit to your insurance company for reimbursement. If you would like to keep a credit card on file for payments and/or shipments, please provide us with your credit card information.

Visa MasterCard American Express Discover

Card #:________________________________Exp.:__________________Security Code:___________
(last 3 digits on back of card)

Cardholder Name:_______________________________Signature:____________________________

I authorize Dr. Andrea Cole-Raub to keep my signature on file and charge services and/or products on an ongoing basis. I understand that this form is valid unless I cancel the authorization through written notice.

I have read the above billing information and give my consent for treatment at this medical center.

Signature:____Date:_______________________