

Patient Registration

Mr. Mrs. Miss Ms. Dr

Patient _____ Today's Date _____
Last Name First Name MI

Address _____
Street City State zip

Birth Date ____/____/____ Age _____ Social Security # _____ Home Phone (____) _____

Work Phone (____) _____

Patient's Employer _____ Cell Phone (____) _____

Patient's Occupation _____ Marital Status Single Married
 Widowed Divorced

Spouse's Name _____ Spouse's Employer _____
Last Name First Name

** Patient Insurance Information **

Primary Insurance _____ Secondary Insurance _____

Please provide a copy of your insurance card and driver's license to verify your signature and date of birth

Person Responsible for Bill – Insurance Guarantor

What is your relationship to the person who is primary insured on your plan? Self Spouse Child Other Dependent

Name of primary insured if not patient _____ Social Security # _____
Last Name First Name

Address of primary insured _____ Phone (____) _____
Street City State

Date of Birth of person who is primary insured on your plan (**IMPORTANT**) _____

Emergency Information and Release

In case of an emergency, friend or relative to be notified (at different address) Name _____

Relationship to patient _____ Home Ph (____) _____ Work Ph(____) _____

Assignment and Release: I hereby authorize my insurance and government benefits to be paid directly to the physician. I am financially responsible for any balance due. Payment is due for all services at the time rendered unless you are scheduled for a procedure that requires prepayment prior to the date of service. We accept cash, check, Visa, MasterCard and Discover.

I also authorize the release of medical information to my primary care physician, to consultants if needed and as necessary to process insurance claims, insurance applications and prescriptions.

Patient Signature _____

Other Information

Were you referred to us by your doctor? Yes No (____) _____
Referring Physician telephone

Referring Physician _____ Address _____
Name

May we contact you about upcoming or missed appointments? Yes No Best phone # (____) _____

Would you like to receive a copy of our electronic newsletter and information on specials on cosmetic procedures? Yes No

Email address _____