

Patient Registration



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

Address _____
Street City State Zip

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

Work Phone (____) _____

Employer _____ Cell Phone (____) _____

Occupation _____ Marital Status: Single Married Legally Separated
 Widowed Divorced Life Partner

In order to better assess medical risks and benefits, we need to ask how you identify your race and ethnicity.

Would you like to provide that information? African American Asian White Hawaiian Native American No Response

Ethnicity: Hispanic or Latino Not Hispanic or Latino

****Patient Provider Information****

Your primary care (family) physician (PCP) _____ Phone (____) _____

Provider who referred you (if any) _____ Phone (____) _____

Please have a copy of your insurance cards and driver's license or photo ID to verify your signature and date of birth

****Patient Insurance Information****

First Insurance _____ Relationship to primary holder Self Spouse Child Other

Second Insurance _____ Relationship to secondary holder Self Spouse Child Other

Name of insured if not self _____ Social Security # _____ D.O.B _____
First Name Last Name

Address of insured if not self _____ (____) _____
Street City State Zip

****For Dependents/Students person responsible for bill** _____

****Emergency Contact Information****

In case of an emergency, friend or relative to be notified Name _____

Relationship _____ Home Phone (____) _____ Work Phone (____) _____

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

Would you be interested in receiving emails on any upcoming cosmetic promotions and specials? If yes, please provide us with your

Email address _____

****Assignment of Benefits and Information Release Authorization****

Assignment and Release: I authorize my insurance and government benefits to be paid directly to the physician. I authorize the release of medical information to my primary care physician, referring physician and medical consultants if needed and as necessary to process insurance claims, insurance applications and prescriptions.

Patient Signature _____