

Patient Registration

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 Legally Separated
 Widowed Divorced Life Partner

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

Patient Provider Information

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

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

Patient Insurance Information

Primary _____ Relationship to primary holder Self Spouse Child Other Dependent

Secondary _____ Relationship to secondary holder Self Spouse Child Other Dependent

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

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

Birth date of insured (other than yourself) _____ (IMPORTANT)

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.

Emergency Contact Information

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

Name _____

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

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

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 _____

Patient Signature _____