

PATIENT REGISTRATION INFORMATION

Name: _____
FIRST LAST MI

What would you like to be called? _____ Date of Birth: _____ Age: _____ Sex: M F

Home Address: _____

City: _____ State: _____ ZIP: _____

Home Phone:(____) _____ Work Phone:(____) _____ Cell: (____) _____

EMAIL ADDRESS _____ It is okay to send occasional specials/newsletter: Yes

Social Security Number: _____ Occupation: _____

Employer's Name & Address: _____

If student: Full Time Part Time Name of School _____

Marital Status: Minor Single Married Widowed Divorced Separated Partner

Name of Spouse (*or Parents if Minor*): _____

Patient's Medical Doctor (Internist/Family Practitioner/Pediatrician): _____

Address: _____ Phone:(____) _____

Pharmacy name & phone number: _____

How did you hear about us?/*Referred by*?: _____

SPOUSE (OR PARENTS/GUARDIAN) INFORMATION

Spouse Parent Guardian

Name: _____ Date of Birth: _____ Social Security # _____

Employer: _____ Work Phone:(____) _____

PAYMENT INFORMATION

Office Policy: Payment is expected at the time of your visit for any deductibles, co-payments, unpaid Medicare or insurance balances and any cosmetic procedures or skin care products. We appreciate your cooperation in settling your account at each office visit. If your insurance plan is responsible for payment, please present your insurance card to our reception desk.

PRIMARY INSURANCE:

Name of Insurance Co: _____ Policy Holder's Name _____

Date of Birth: _____ SS#: _____ Relation to Patient: _____

SECONDARY INSURANCE:

Name of Insurance Co: _____ Policy Holder's Name _____

Date of Birth: _____ SS#: _____ Relation to Patient: _____

Do we have permission to: Leave a message on your answering machine at home? Yes No

Leave a message at your place of employment? Yes No

Discuss your medical condition with any member of your household? Yes No

If yes, whom: _____ Relationship _____