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**:(____)_____**Other:** (____)_____

Email address _____ It is okay to send occasional emails: 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

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_____