Patient Registration

Please Print

Patient Name_____ Today's Date _____Patient # [ ]

Address _____

(Physical address mandatory) City State Zip Code

Birthdates/Age_____ ☐ Female ☐ Male

Home Number _____Cell Number _____ Work Number _____

*Email Address_____

Employer and Address_____

Name Street/State Zip Code

Occupation_____

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Family Physician_____

Referred to this office by: Physician (name) _____ ☐ Website ☐ Magazine ☐ Newspaper

☐ Television Other (details)

Spouse's Name _____Spouse's Employer_____

Home, Work, Cell (Please circle)

Is it acceptable to leave a detailed message on any of the above numbers? ☐ Yes ☐ No

If not may we leave a message at home "This is a follow up call?" ☐ Yes ☐ No

*Is it acceptable to email promotions, newsletters or appointment reminders? ☐ Yes ☐ No

IF PATIENT IS A MINOR, PARENT OR GUARDIAN INFORMATION

Name_____Relationship to Patient_____

Address_____Home Number_____

Street City State Zip Code

IN THE UNLIKELY EVENT OF AN EMERGENCY, LOCAL RELATIVE OR FRIEND TO BE NOTIFIED (NOT LIVING AT THE SAME ADDRESS)

Name_____Relationship to Patient_____

Home Phone Number _____Cell Number_____ Work Number_____

PLEASE PUT A CHECK MARK NEXT TO THE PROCEDURES ABOUT WHICH YOU WOULD LIKE TO RECEIVE MORE INFORMATION:

☐ Botox	☐ Sun Damage	☐ Wrinkles
☐ Fillers	☐ Brown Spots	☐ Shaving Bumps/Ingrown Hair
☐ Enhanced Skin Rejuvenation	☐ Broken Capillaries/Facial Redness	☐ Laser Hair Removal
☐ Skin Toning or Pore Size	☐ Spider Veins/Leg Veins	☐ Permanent Makeup

INSURANCE INFORMATION

Primary Insurance _____ Secondary Insurance_____

Subscribers Name _____ Subscriber's Name _____

ID/Claim #_____ID/Claim #_____

Group # _____ Group # _____

Product and treatment Purchases:

We stand behind all products sold to our patients and will gladly exchange/refund the item (i.e. allergic reaction, incorrect color etc.) within 30 days of purchase. All items purchased with a credit card will be refunded to the same card. All items purchased with cash or check will be credited by check and may take up to 4 weeks to receive by mail. We apologize for any inconvenience. **All prepaid laser treatment packages are non-refundable.**

ASSIGNMENT AND RELEASE

I ACKNOWLEDGE THAT THE ABOVE INFORMATION IS CORRECT. I ALSO AUTHORIZE MY INSURANCE BENEFITS TO BE PAID DIRECTLY TO THE PHYSICIAN AND I AUTHORIZE THE DOCTOR AND OR INSURANCE COMPANY TO RELEASE ANY INFORMATION REQUIRED FOR PAYMENT OF THIS CLAIM. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ANY BALANCE DUE AND I AGREE TO PAY IF MY INSURANCE COMPANY DOES NOT PAY WITHIN 90 DAYS OF BEING BILLED.

SIGNATURE_____ DATE_____

(Patient, Parent or Guardian)