

PATIENT REGISTRATION INFORMATION

FIRST NAME _____ MI _____ LAST _____ SS#: _____

ADDRESS: _____ PHONE#: _____

CITY: _____ STATE: _____ ZIP: _____

SEX: M _____ F _____ AGE: _____ BIRTHDATE: _____

E-MAIL ADDRESS: _____ CELL PHONE#: _____

EMPLOYER: _____ EMPL/PHONE#: _____

OCCUPATION: _____

MARITAL STATUS: _____ SPOUSES NAME: _____ SS#: _____

PERSON RESPONSIBLE FOR THIS ACCOUNT: _____

PLEASE COMPLETE THE INFORMATION BELOW AS APPLICABLE :

SPOUSES/RESPONSIBLE PARTY EMPLOYER: _____

EMPL/ADDRESS: _____ CITY: _____

STATE: _____ ZIP: _____ PHONE#: _____

WHO REFERRED YOU TO OUR PRACTICE ? _____

WHAT ARE YOU BEING SEEN FOR TODAY ? _____

NEAREST FRIEND OR RELATIVE: _____

NOT AT SAME ADDRESS:

HOME PHONE# : _____ WORK PHONE# : _____

DO YOU HAVE MEDICAL INSURANCE? YES: _____ NO: _____

PRIMARY INSURANCE: _____ PHONE# : _____

INSURED NAME: _____ SS#: _____ GRP#: _____

BIRTHDATE _____ ID# _____

PLEASE HAVE ALL INSURANCE CARDS AND DRIVERS LICENSE AVAILABLE FOR COPYING.

ALL PATIENTS, PLEASE READ THE FOLLOWING DISCLOSURE AND SIGN.

IN ORDER TO CONTROL OUR COST OF BILLING, WE REQUEST PAYMENT BE MADE AT THE TIME SERVICE IS RENDERED.

AUTHORIZATION: I HEREBY AUTHORIZE DR. PIN, FOR A PERIOD OF TEN YEARS, TO FURNISH AND/OR ELECTRONICALLY TRANSMIT ANY BILLING AND/OR MEDICAL RECORD INFORMATION TO INSURANCE CARRIERS, ATTORNEYS, ANY THIRD PARTY MEDICAL RECORD RETRIEVAL SERVICE, OR ANY ENTITY NECESSARY IN THE COLLECTION OF FEES IN REGARD TO THIS ILLNESS/ACCIDENT. I HEREBY IRREVOCABLY ASSIGN TO DR. PIN ALL PAYMENTS FOR MEDICAL SERVICES RENDERED. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT COVERED BY INSURANCE.

PATIENT SIGNATURE: _____ DATE: _____

RESPONSIBLE PARTY SIGNATURE: _____ DATE: _____

PLEASE LET US KNOW IF YOU WOULD YOU BE INTERESTED IN LEARNING ABOUT ANY OF THE FOLLOWING PROCEDURES:

Facelift _____

Liposuction _____

Breast Lift _____

Nose Surgery _____

Eyelid Surgery _____

Tummy Tuck _____

Breast Enlargement _____

Other Cosmetic Surgery _____