



AESTHETIC SURGERY GROUP
FULL BODY PLASTICS
DERMATOLOGY
SKIN CARE

Patient Registration Form

Patient Name _____ Date _____
Last First Middle

If patient is a minor, lives with _____ Relationship _____

Birthdate _____ Age _____ Sex _____ Social Security # _____

Address _____
Street City, State Zip

Home Phone (_____) _____ Work Phone (_____) _____

Marital Status: Single Married Widowed Divorced Separated Other _____

Employed Occupation _____ Retired Full-time Student Part-time Student

Employer/ and or school Name and Address _____

Spouses Name _____ Social Security # _____ Birthdate _____

Responsible Party: If Other than the Patient, Please Complete

Name _____ Relationship to Patient _____

Address, if other than same _____

Home Phone (_____) _____ Work Phone (_____) _____ Social Security # _____

Responsible Party's Birthdate _____ Employer Name & Address _____

Emergency Contact. Nearest Friend/Relative Not Living With You

Name _____ Relationship to Patient _____

Address _____ Phone (_____) _____

Referring Physician/ Medical Insurance Information

Name of Referring Physician _____ Phone # _____

Name of Family or Primary Care Physician _____ Phone # _____

Do you have medical insurance to cover your examination or treatment? Yes No

If Yes, we will take a copy of your insurance cards. *If you do not have an insurance card, please indicate ins. carrier name and your I.D. #* _____

Does your insurance company require an authorization or referral for exam or treatment from a Primary Care Physician? Yes No If Yes, Physician's name _____

Accident Information. Complete if your treatment is for an injury or accident.

Were you injured at work? Yes No Is this covered by Workman's Compensation? _____

If Yes, Contact person at your Employer _____

Date & time of Accident _____ Place of Accident _____

How did injury happen? _____

Name of Physician who treated you at time of accident _____

Financial Responsibility Statement/ Release of Information Authorization

"I authorize the release of any medical information necessary to my insurance company and the Payment of Benefits to the Physician for services received. I also authorize the release of information to listed physicians and/ or individuals."

X _____ Date _____
Signature of Patient or Legal Guardian

"I acknowledge responsibility for payment of all medical fees regardless of insurance I may have to assist me in this responsibility. The only exception will be charges for services covered under a contractual agreement that has been entered into between my physician and an insurance company, HMO, or other managed care entity. If for any reason the account should become delinquent, I am liable to pay for all collection and legal fees."

X _____ Date _____
Signature of Patient or Legal Guardian

In connection with the medical services which I am receiving from my physician, I consent that photographs may be taken of me under the following conditions; 1.) The photographs may be taken only with the consent of the physician, and under such conditions and at such times as may be approved by him. 2.) The photographs shall be taken by my physician or by a photographer approved by my physician. 3.) The photographs shall be used for medical records and if in the judgement of my physician, medical research, education or science will benefit by their use. Such photographs and information relating to my case may be published and republished either separately or in connection with each other which he may deem proper for these purposes. It is specifically understood that in any such publication or use I shall not be identified by name. 4.) The aforementioned photographs may be modified or retouched in any way that my physician, in his discretion, may consider desirable.

X _____ Date _____
Signature of Patient or Legal Guardian