

FILL OUT AND SEND IN PRIOR TO APPOINTMENT

PATIENT REGISTRATION (PLEASE PRINT AND ANSWER ALL QUESTIONS IN FULL)

Patient Information (please complete using your name as listed on your insurance card)

First Name: _____ Middle Initial: _____ Last Name: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Occupation: _____ Employer: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Date of Birth: _____ Age: _____ SS#: _____

Marital Status: Single _____ Married _____ Divorced _____ Widowed _____ Sex: M _____ F _____

Race: _____ Preferred Language: _____ Ethnicity: _____

Pharmacy Name: _____ Street/City: _____

Pharmacy Phone #: _____ Pharmacy Fax#: _____

Insurance Information All Patients must provide a copy of their insurance card at every visit

Primary Insurance: _____ Name of Insured: _____ Relationship: _____

Secondary Insurance: _____ Name of Insured: _____ Relationship: _____

Tertiary Insurance: _____ Name of Insured: _____ Relationship: _____

Insurance Responsibility Is the patient the person responsible for the insurance? No _____ Yes _____

If no, please answer the following questions about the person who is responsible.

First Name: _____ Middle Initial: _____ Last Name: _____

Street Address: _____ City: _____ St: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Date of Birth: _____ SS#: _____

Occupation: _____ Employer: _____ Sex: M _____ F _____

Referring Physician Information

Referring Physician: _____ Phone #: _____

Primary Care: _____ Phone #: _____

Information Release: The staff at Laser and Skin Surgery Center of Indiana considers all patient information confidential. A copy of the office's HIPAA policy is available upon request.

IN THE EVENT OF AN EMERGENCY you may discuss my medical condition, test results, billing, and/or treatment at Laser and Skin Surgery Center of Indiana with the following individuals (please do NOT list any physicians' names)

Name: _____ Relationship: _____ Phone#: _____

Name: _____ Relationship: _____ Phone#: _____

Name: _____ Relationship: _____ Phone#: _____

PATIENT SIGNATURE (if minor, parent/legal guardian)

DATE

X _____

SIGN HERE