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 ______ Widow ______ 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