



PATIENT REGISTRATION INFORMATION

Name _____
FIRST MI LAST

Preferred Name (If different from above) _____ E-mail _____
Email is used for appt reminders & newsletters

Home Address: _____ City: _____ State: _____ ZIP: _____

Home Phone: (____) _____ Work: (____) _____ Cell: (____) _____
Please check one of the boxes to indicate preferred contact number for automated appointment confirmation

Social Security Number: _____ Date of Birth: _____ Sex: M F

Marital Status: Minor Single Married Widowed Divorced Separated

Occupation: _____

Employer's Name & Address: _____

Patient's Medical Doctor (Internist/Family Practitioner/Pediatrician): _____

Pharmacy Name, Location & Phone Number: _____

How did you hear about us? Referred by? _____

EMERGENCY CONTACT/SPOUSE OR PARENTS/GUARDIAN INFORMATION

Name: _____ Phone (____) _____ Relationship: _____
(H) (W) (C)

PRIMARY INSURANCE:

Name of insurance Co: _____

Policy Holder's Name: _____ Date of Birth: _____ ID or SS#: _____

Relation to patient: _____

What is the name of your Prescription carrier? (if applicable) _____

SECONDARY/SUPPLEMENTAL INSURANCE (if applicable):

Name of Insurance Co: _____

Policy Holder's Name: _____ Date of Birth: _____ ID or SS#: _____

Relation to patient: _____

Office Policy: Payment is due at the time of your visit for any deductibles, co-payments, unpaid insurance balances and any cosmetic procedures or skin care products. We appreciate your cooperation in settling your account at each office visit.

By signing below, I acknowledge that I am the guarantor of this account; I am responsible for co-pays, deductibles or any other balances due to Pierre Skin Care Institute.

Patient Signature (Parent/guardian if patient is a minor)

Print Name

Date