



PATIENT REGISTRATION

Patient Name: _____ DOB: _____ Age: _____
(Last) (First) (MI) (Preferred Name)

Mailing Address: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Gender: _____ M / F

Email Address: _____

Home Phone: _____ Other Phone: _____ cell / work

Emergency Contact: _____ Relationship to Patient: _____

Emergency Contact Phone: (h) _____ (w) _____ (cell) _____

Primary Care Provider: _____ Referring Physician: _____

How did you learn about our office? Yellow Pages: _____ Radio - Station: _____ Internet: _____
Physician: _____ Patient: _____ May we thank them? _____ Y / N

Other: _____ (ex: magazine, newspaper, or mailer)

Your photo will be taken and kept in your chart to track your progress. Do you consent to having your (anonymous) photo(s) used in our office for educational purposes? Yes _____ No _____

Authorization to Release Information: I hereby authorize the Physicians of Associated SkinCare to release any information acquired in the course of my treatment necessary to process insurance claims. **Authorization to Pay Benefits to the Physicians of Associated SkinCare:** I hereby authorize payment directly to the Physicians of Associated SkinCare of the Surgical and/or Medical Benefits, if any, otherwise payable to me for his services as described, realizing that I am responsible to pay all non-covered services, co-payments and co-insurances. In the event that the services rendered are not covered by my insurance policy I, as the patient will be responsible for payment in full.

Non-Covered Services Payment Policy: Payment for treatment is due in full on the date service is rendered. We gladly accept MasterCard, Visa, American Express, check, and/or cash.

Patient Signature (Guardian if Patient is a minor)

Date