

Please complete the following confidential information

# PATIENT REGISTRATION

**IF THIS APPOINTMENT IS FOR YOUR CHILD — START HERE** *Please Print*

CHILD'S NAME \_\_\_\_\_ FIRST \_\_\_\_\_ M.I. \_\_\_\_\_ LAST \_\_\_\_\_ PREFERS TO BE CALLED \_\_\_\_\_

ADDRESS \_\_\_\_\_ STREET \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_ HOME PHONE \_\_\_\_\_

DATE OF BIRTH \_\_\_\_\_ AGE \_\_\_\_\_  MALE  FEMALE SCHOOL \_\_\_\_\_ GRADE \_\_\_\_\_

**IF THIS APPOINTMENT IS FOR YOU — START HERE**

NAME \_\_\_\_\_ FIRST \_\_\_\_\_ M.I. \_\_\_\_\_ LAST \_\_\_\_\_ PREFERS TO BE CALLED \_\_\_\_\_

ADDRESS \_\_\_\_\_ STREET \_\_\_\_\_ HOME PHONE \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_ CELL PHONE \_\_\_\_\_

DATE OF BIRTH \_\_\_\_\_ AGE \_\_\_\_\_  MALE  FEMALE /  MARRIED  SINGLE  DIVORCED  WIDOWED

SS# \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ OCCUPATION \_\_\_\_\_ EMPLOYER'S NAME \_\_\_\_\_

(LAST 4 DIGITS REQUIRED)

WORK ADDRESS \_\_\_\_\_ STREET \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_ WORK PHONE \_\_\_\_\_  YES  NO OK TO CALL WORK

**GETTING TO KNOW YOU**

IS ANOTHER MEMBER OF YOUR FAMILY OR A RELATIVE A PATIENT AT OUR OFFICE? \_\_\_\_\_

NAME \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_

WHO CAN WE THANK FOR REFERRING YOU TO OUR OFFICE? \_\_\_\_\_

MEDICAL DOCTOR \_\_\_\_\_ PHONE \_\_\_\_\_

PERSON TO CONTACT IN CASE OF EMERGENCY (OTHER THAN YOUR FAMILY HOME)

NAME \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_ WORK# \_\_\_\_\_ HOME# \_\_\_\_\_

**ACCOUNT INFORMATION**

PERSON FINANCIALLY RESPONSIBLE FOR ACCOUNT  SAME AS PATIENT

NAME \_\_\_\_\_ FIRST \_\_\_\_\_ M.I. \_\_\_\_\_ LAST \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_ SS# \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

ADDRESS \_\_\_\_\_ STREET \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_ HOME PHONE \_\_\_\_\_

SPOUSE'S NAME \_\_\_\_\_ FIRST \_\_\_\_\_ M.I. \_\_\_\_\_ LAST \_\_\_\_\_ SPOUSE'S DATE OF BIRTH \_\_\_\_\_

SPOUSE'S EMPLOYER \_\_\_\_\_ SPOUSE'S OCCUPATION \_\_\_\_\_

SPOUSE'S WORK ADDRESS \_\_\_\_\_ STREET \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_ WORK PHONE \_\_\_\_\_  YES  NO OK TO CALL WORK

**MEDICAL INSURANCE**

<p>INSURANCE COVERAGE <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>INSURANCE COMPANY</p> <p>NAME _____</p> <p>ADDRESS _____</p> <p>PHONE NO. _____</p> <p>GROUP/PROGRAM NO. _____</p> <p>SUBSCRIBER'S</p> <p>NAME _____</p> <p>DATE OF BIRTH _____</p> <p>SS# _____</p> <p>PATIENT'S RELATIONSHIP TO SUBSCRIBER</p> <p><input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> DEPENDENT</p>	<p>SECONDARY COVERAGE <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>INSURANCE COMPANY</p> <p>NAME _____</p> <p>ADDRESS _____</p> <p>PHONE NO. _____</p> <p>GROUP/PROGRAM NO. _____</p> <p>SUBSCRIBER'S</p> <p>NAME _____</p> <p>DATE OF BIRTH _____</p> <p>SS# _____</p> <p>PATIENT'S RELATIONSHIP TO SUBSCRIBER</p> <p><input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> DEPENDENT</p>
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**Please turn over and sign**

# CONSENT FOR TREATMENT

1. I consent to the making of videotapes and photographs before, during and after treatment, and to the use of same by the doctor in scientific papers or demonstrations.
2. I give consent to the doctor's or designated staff's use and disclosure of any oral, written or electronic health records that are individually identifiable as mine for the purpose of carrying out my treatment, payment and health care operations. I give consent to allow **Eye Plastic & Facial Cosmetic Surgery, P.C.** (AKA *Plastic & Reconstructive Eye Surgery, P.C.*) to obtain my personal medical history and/or necessary medical records for the purpose of carrying out my treatment, payment and health care operations.
3. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that my insurance company will be billed and that I am responsible for all co-payments and deductibles not covered by insurance.
4. I have received a copy of the Notice of Privacy Practices for **Eye Plastic & Facial Cosmetic Surgery, P.C.** (AKA *Plastic & Reconstructive Eye Surgery, P.C.*)

Patient's Signature \_\_\_\_\_ Date \_\_\_\_\_

Parent / Responsible Party's Signature \_\_\_\_\_

Relationship to Patient \_\_\_\_\_