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

____ (Initial) I grant permission to Pierre Skin Care Institute to send me a secured email, or leave a message regarding my condition and/or my bill on the following numbers provided above: Home ___, Work___, Cell___ (check all that apply)

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): ___ _____

How did you hear about us? Referred by? _____

EMERGENGY 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