PHYSICIANS LASER AND DERMATOLOGY INSTITUTE, LLC PATIENT REGISTRATION FORM

(Please Complete Entire Form)

City State Zip Code Telephone Nos. (H) (W) (C) Date Of Birth: _/_ Age: Sex:	Patient's NameLa		•		
City State Zip Code Telephone Nos. (H) (W) (C) Date Of Birth: / / Age: Sex: Marital Status: S\$#: Occupation: Employer's Name & Address: Spouse/If Minor, Parent's) Name(s): Spouse's Date Of Birth: / / Occupation: Guarantor's Employer: Address Telephone No. Referring Physician's Name, Address Zip Code: Telephone No. Specialty Primary Physician's Name, Address & Zip Code: Telephone No. Specialty Person Responsible For Bill: Primary Insurance Carrier: Insured's Name: Insured's Birthdate: Insured's S\$#: Group ID#: Relationship: Secondary Insurance Carrier: Insured's Name: Insured's Birthdate: Insured's Name: Insured's Birthdate: Insured's Name: Insured's Birthdate: Insured's S\$#: Group ID#: Relationship: ***********************************	La	st	First		Middle Initial
Telephone Nos. (H)	Home Address		Ci tu	<u> </u>	R' - C-1
Date Of Birth:/ Age: Sex: Marital Status:					_
SS#: Occupation: Employer's Name & Address:	Telephone Nos. (H)	(W	1)	(C)	
Address: Spouse/If Minor, Parent's) Name(s): Spouse's Date Of Birth: / / Occupation: Guarantor's Employer: Address Telephone No. Referring Physician's Name, Address & Zip Code: Telephone No. Specialty Primary Physician's Name, Address & Zip Code: Telephone No. Specialty Person Responsible For Bill: Primary Insurance Carrier: Insured's Name: Insured's Birthdate: Insured's S\$\frac{1}{2}\$ Group ID\frac{1}{2}\$: Relationship: Secondary Insurance Carrier: Insured's Name: Insured's Birthdate: Insured's S\$\frac{1}{2}\$ Group ID\frac{1}{2}\$: Relationship: ***********************************	Date Of Birth:/	_/ Age:	Sex:	Marital St	atus:
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Guarantor's Employer: Address Telephone No. Referring Physician's Name, Address & Zip Code: Telephone No. Specialty Primary Physician's Name, Address & Zip Code: Telephone No. Specialty Person Responsible For Bill: Primary Insurance Carrier: Insured's Name: Insured's Sit: Group ID#: Relationship: Secondary Insurance Carrier: Insured's Name: Insured's Birthdate: Insured's Name: Insured's Birthdate: Insured's Sit: Relationship: ***********************************	Spouse/If Minor, Parent's	s) Name(s):			
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to release any information required to process my insurance claims (in any). Patient's Signature Date	to be paid directly t	to the physic	ian. I als	so authorize	the physician
Patient's Signature Date	to release any inform	mation require	ed to proce	ess my insur	ance claims (if
racione o organicaro					
	Patient's Signat			<u>.</u>	Date
75 T. 7 T.	,				
Signature Of Parent/Guardian If Under 18-Years-Of-Age (Relationship)	Signature Of Parent.	/Guardian If	Under 18-Ye	ears-Of-Age	(Relationship)

PHYSICIANS LASER AND DERMATOLOGY INSTITUTE, LLC PATIENT REGISTRATION FORM (CONT'D.)

To establish optimal relations with our patients, and to avoid any misunderstanding regarding our payment policies, our staff is trained to inform you of the financial policies of this office. PAYMENT OF "YOUR SHARE" OF THE CHARGES IS EXPECTED FROM YOU AT THE TIME OF SERVICE. FOR YOUR CONVENIENCE, BESIDES CASH AND CHECKS, WE ALSO ACCEPT VISA, MASTERCARD AND DISCOVER CREDIT CARDS FOR PAYMENT. Your signature below indicates that you understand and accept this policy.

Signature Of Patient (Parent/Legal Guardian If Minor)	Date
*************	*****
In the event your account falls in arrears greater than authorize the unpaid balance to be charged to my major collisted below:	90 days, I redit card, as
() Visa () Mastercard () Discover	
Card No: Expiration Date:	
Name As It Appears On The Card:	
Authorized Signature	Date