PHYSICIANS LASER AND DERMATOLOGY INSTITUTE, LLC
PATIENT REGISTRATION FORM
(Please Complete Entire Form)

Patient's Name _____
Last First Middle Initial

Home Address _____
City State Zip Code

Telephone Nos. (H)_____ (W)_____ (C)_____

Date Of Birth: ____/____/____ Age: _____ Sex: _____ Marital Status: _____

SS#: _____ 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 SS#:_____ Group ID#:_____ Relationship:_____

Secondary Insurance Carrier: _____

Insured's Name: _____ Insured's Birthdate: _____

Insured's SS#:_____ Group ID#:_____ Relationship: _____

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ASSIGNMENT AND RELEASE: I hereby authorize my insurance benefits to be paid directly to the physician. I also authorize the physician to release any information required to process my insurance claims (if any).

_____
Patient's Signature Date

_____
Signature Of Parent/Guardian If Under 18-Years-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

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In the event your account falls in arrears greater than 90 days, I authorize the unpaid balance to be charged to my major credit card, as listed below:

( ) Visa ( ) Mastercard ( ) Discover

Card No: _____ Expiration Date: _____

Name As It Appears On The Card: _____

_____ _____

Authorized Signature Date