PATIENT REGISTRATION

DOCTOR Feins

Patient Information

☐Mr. ☐Mrs. ☐Ms. ☐Dr. First Name: ____________________M.I.____Last Name__________________________

Address:____ City:___________________ State:_____ Zip:_______

Age:______ Date of Birth:____________________ Email Address:____________________________________

Gender: ☐Male ☐Female Marital Status: ☐Single ☐Married ☐Widowed ☐Divorced ☐Other

Home Phone #: ________________ Work Phone #:_________________ Cell Phone #:___________________

Preferred contact phone number: ☐Cell Phone ☐Home Phone May we contact your home and leave a message with other residents? ☐YES ☐NO IF yes, with whom are we authorized to leave messages?

____ Relationship to Patient:___________________________

May we leave messages on your answering machine or home voice mail? ☐YES ☐NO

May we send and receive information with you via the internet? ☐YES ☐NO

Medical Information

Reason for today's visit (please check all that apply): ☐Breasts ☐Waist/Abdomen ☐Skin ☐Face ☐Forehead ☐Eyes ☐Lips ☐Neck ☐Thighs ☐Legs ☐Back ☐Body ☐Buttocks ☐Suspicious Lesion ☐Cyst ☐Reconstructive Procedure: ______________________________ ☐Other:______________________

Accident? ☐YES ☐NO If yes, date: _________ Auto Accident? ☐YES ☐NO If yes, date: ____________

How did you hear about us? Referred by: ____

☐Friend/Relative/Other patient: _________________________________ ☐Website:________________________

☐Yellow Pages: __________________ ☐Print ad: _______________________________________(please identify)

Primary Care Physician: _________________________________ Primary Care Phone #:________________

Patient's Employment Information

Employer: ____

Employer's Address: __________________________________ City: ____________ State: ____ Zip: ________

Occupation: ___________________________ Employment Status: ☐Full Time ☐Part Time ☐Not employed ☐Self Employed ☐Retired ☐Full Time Student ☐Part Time Student

Health Insurance Information (We will make a copy of your insurance card)

Primary Health Insurance Co: _______________________________ Policy Number:______________________

Subscriber's Name:_________________________________ Subscriber's Date of Birth: ____________________

Subscriber's Age: ____ Subscriber's Gender: ☐Male ☐Female Subscriber's Relationship to Patient: ________

COBRA? ☐YES ☐NO Subscriber's Address: ____

City: __________________________ State: ____ Zip: ________

Subscriber's Employer:____________________________ Employer's Address:___________________________

City: ________________________________ State: ____ Zip: ______

Financial Responsibility

I understand and agree that regardless of my insurance status and regardless of any insurance prior approvals, I am ultimately responsible for the entire balance of my account for any professional services rendered.

I have read all the information and have completed all answers. I certify that the foregoing information is true and correct. I will notify you promptly of any changes in my status or in the above information.

Signed: ____ Date: ________________

(Parent/Legal Guardian if patient is under 18 years old)