Patient Registration

Date: _____

First Name	First Name				
Home Phone - Cell Phone - Work Phone - - Date of Birth / Social Security Number / / Marital Status Sex: Male Female Employment Status: (circle one) Retired Full time Part time Unemployed Occupation Employer Please list below any person(s) that we may speak to or contact on your behalf in case of an emergency: Contact Person Relationship Telephone - Contact Person Relationship Telephone - - Responsible Party (if different from patient) First Name Middle Initial Last Name Zip Primary Telephone () Secondary Telephone () Sex Relationship: (circle one) Spouse Parent Child Other Employment Status: (circle one) Retired Full-time Parent-time Unemployed Occupation Employer Employer Employer Employer		_ Middle Initial	_ Last Name		
Date of Birth // Social Security Number // Marital Status Sex: Male Female Employment Status: (circle one) Retired Full time Part time Unemployed Occupation	Address	City		State	Zip
Marital Status Sex: Male Female Employment Status: (circle one) Retired Full time Part time Unemployed Occupation Employer Please list below any person(s) that we may speak to or contact on your behalf in case of an emergency: Contact Person Relationship Telephone - Contact Person Relationship Telephone - - Responsible Party (if different from patient) Telephone - - First Name Middle Initial Last Name Zip Address City State Zip Primary Telephone () Social Security Number / Sex Date of Birth / / Social Security Number / Sex Relationship: (circle one) Spouse Parent Child Other Employment Status: (circle one) Retired Full-time Part-time Unemployed Occupation Employer Employer	Home Phone	_ Cell Phone		Work Phone	
Employment Status: (circle one) Retired Full time Part time Unemployed Occupation Employer Please list below any person(s) that we may speak to or contact on your behalf in case of an emergency: Contact Person Relationship Telephone - Contact Person Relationship Telephone - - Contact Person Relationship Telephone - - Responsible Party (if different from patient) First Name	Date of Birth//	Social Security	Number	//	
Occupation Employer Please list below any person(s) that we may speak to or contact on your behalf in case of an emergency: Contact Person Relationship Telephone - Contact Person Relationship Telephone - - Responsible Party (if different from patient) Relationship Telephone - - First Name Middle Initial Last Name Address City State Zip Primary Telephone () Secondary Telephone () - Date of Birth / Social Security Number / Sex Relationship: (circle one) Spouse Parent Child Other Employment Status: (circle one) Retired Full-time Part-time Unemployed Occupation Employer	Marital Status	Sex: Male	Female		
Please list below any person(s) that we may speak to or contact on your behalf in case of an emergency: Contact Person Relationship Telephone - Contact Person Relationship Telephone - Contact Person Relationship Telephone - Responsible Party (if different from patient) Telephone - - First Name Middle Initial Last Name	Employment Status: (circle one) Retir	ed Full time	Part time	Unemployed	
Contact Person Relationship Telephone - - Contact Person Relationship Telephone - - Responsible Party (if different from patient) First Name Middle Initial Last Name - Address City State Zip Primary Telephone () Secondary Telephone () - - Date of Birth / / Social Security Number / / Relationship: (circle one) Spouse Parent Child Other Employment Status: (circle one) Retired Full-time Part-time Unemployed Occupation Employer Employer - - - Medical Information Referring Physician's Name Phone Phone -	Occupation	Emplo	oyer		
Responsible Party (if different from patient) First Name	Contact Person	Relationship_		Telephone	
First Name		Relationship_			
Date of Birth / / Social Security Number / / Sex Relationship: (circle one) Spouse Parent Child Other Employment Status: (circle one) Retired Full-time Part-time Unemployed Occupation Employer Employer Employer Employer Medical Information Referring Physician's Name Phone Phone	First Name Address	Middle Initial City		State	Zip
Relationship: (circle one) Spouse Parent Child Other Employment Status: (circle one) Retired Full-time Part-time Unemployed Occupation Employer Medical Information Referring Physician's Name Phone					
Employment Status: (circle one) Retired Full-time Part-time Unemployed Occupation Employer			Number	/ /	
Referring Physician's Name Phone Phone		Daront			sex
	Relationship: (circle one) Spouse Employment Status: (circle one)	Retired Full-ti	Child ne Part-tin	Other ne Unemployed	
Primary Care Physician's NamePhonePhone	Relationship: (circle one) Spouse Employment Status: (circle one) Occupation	Retired Full-ti	Child ne Part-tin	Other ne Unemployed	t t
	Relationship: (circle one) Spouse Employment Status: (circle one) Occupation Medical Information Referring Physician's Name	Retired Full-ti	Child ne Part-tin oyer	Other ne Unemployed	
	Relationship: (circle one) Spouse Employment Status: (circle one) Occupation Medical Information Referring Physician's Name	Retired Full-ti	Child ne Part-tin oyer	Other ne Unemployed	

□ Cosmetic - Self Pay – Insurance information is not required

□ Medical – Please give insurance card to Receptionist

□ Insurance information provided: I hereby give Nadia Blanchet, M.D. permission to release necessary medical information to my insurance company(ies). I further authorize direct payment to the above listed companies. I understand that I am responsible for obtaining referrals, if necessary, and paying any co-payments, coinsurance, or deductibles required by my Plan. I also understand that I may be responsible for the full amount in event of non-coverage determined by my Plan. If my account is not paid when due, I further agree to pay collection expenses of 25% of the balance plus interest accrued after 90 days at 1.5% monthly.

□ No insurance information provided: I agree to pay in full by check, credit card or money order at or before the date of service. If my account is not paid when due, I further agree to pay collection expenses and or attorney fees in the amount of 25% of the balance due, plus interest of 1.5% per month on any balance outstanding for 90 or more days. I understand that my insurance company will not cover cosmetic surgery.