Nadia Blanchet, M.D. **Patient Registration** Date: _____

Patient Information

First Name_____ Middle Initial_____ Last Name_____

Address_____ City_____ State_____ Zip_____

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_____

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_____

Medical Information

Referring Physician's Name_____ Phone_____

Primary Care Physician's Name_____ Phone_____

Insurance Information

☐ 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.**

Patient/Guardian Signature: _____ Date_____

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