RENAISSANCE
DERMATOLOGY & AESTHETICS

Registration (Please Print)

Date: _____ Home Phone: _____ Cell Phone: _____

Name: _____ Name you preferred to be called: _____

Address: _____

Sex ☐ M ☐ F Age_____ Birthdate_____ ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Social Security #:_____ Whom may we thank for referring you?: _____

Preferred Language:_____ Race and Ethnic Group:_____

Employer: _____ Work Phone: _____

Occupation: _____ If Student ☐ Full-time ☐ Part-time ☐ Email Address _____

In case of emergency who should be notified? _____ Phone _____

Do we have permission to:
- Leave a message on your answering machine? ☐ Yes ☐ No
- Leave a message at your place of employment? ☐ Yes ☐ No
- Discuss your medical condition with any member of your household? ☐ Yes ☐ No

If yes, Whom:_____ Relationship: _____

Person responsible for account (information required if patient is a minor)

_____

Name Address City State Zip

Insurance Company _____ Policyholder _____

Policyholder Employer_____ Policyholder Social Security#_____

Patient relationship to Policyholder ☐ Self ☐ Child ☐ Spouse ☐ Other Policyholder Date of Birth _____

In order to establish optimal relations with our patients and avoid misunderstanding regarding our payment policies, our staff is trained to inform you of the financial policies of this office. PAYMENT IS EXPECTED FROM YOU AT THE TIME OF SERVICE FOR YOUR PART OF THE CHARGES. WE ACCEPT VISA, MASTERCARD, AMERICAN EXPRESS AND DISCOVER FOR YOUR CONVENIENCE.

If we are participating providers for your insurance company, we will file your claim. However, any unmet deductible or co-pay is due at the time of service. Be aware that "CO-PAYS" usually cover office visits. Surgical procedures usually fall under deductible. If we do not "participate" with your insurance company, you will be given a statement of office services which should be sent (along with your insurance form) to your insurance company so you may be reimbursed directly.

Please notify us at least two business days in advance if you are unable to keep your appointment. This courtesy allows someone else to be treated - a courtesy you would want if the circumstances were reversed.

Your signature below indicates that you understand and accept these policies. In addition, your signature certifies that you understand that you are financially responsible for all charges whether or not paid by insurance. Further you signature authorizes the doctor to release such medical information necessary to process your insurance claims (if any). You herein authorize payment of medical benefits to the doctor, when an assigned claim is filed.

_____ _____ Circle One: Self Parent Guardian

Signature of Patient or Legal Guardian Date

_____

Print Name

A guardian or adult signature is required if patient is under 18

Please present your insurance cards & photo ID to our receptionist. She will make copies & return them to you promptly

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IMMUNIZATIONS

Flu Vaccine:	☐ No	☐ Yes, most recent year: _____
Pneumonia Vaccine:	☐ No	☐ Yes, most recent year: _____
Shingles Vaccine:	☐ No	☐ Yes, most recent year: _____
Covid Vaccine:	☐ No	☐ Yes, most recent year: _____

SOCIAL

Tobacco Use:	☐ Never	☐ Former	☐ Daily	☐ Occasional
Type:	☐ Cigarette	☐ Cigar	☐ Smokeless	
Alcohol Use:	☐ No	☐ Daily	☐ Weekly	☐ Rarely
Illicit/IV Drug Use:	☐ No	☐ Yes (Type/Frequency: _____)		
Sexually Active:	☐ No	☐ One Partner	☐ Multiple Partners	☐ Same Gender
Healthcare Proxy: *(i.e. Medical Decision Maker)*	☐ Unsure	☐ No	☐ Yes, whom: _____	

I understand the questions above and verify that all information is accurate.

Signature of Patient/Legal Guardian: _____ **Date:**_____