

Patient Registration

Welcome to *The Stern Center for Aesthetic Surgery, P.C.* Please complete this form and return it to the receptionist, who will use the information to prepare your chart.

PLEASE PRINT

How were you referred? _____

If you were referred by an individual, may we send a thank you letter? _____

1. Name _____ Date _____

2. _____
Address _____ City _____ State _____ Zip _____

3. Date of Birth _____ Age _____ Male/Female (Circle One)

4. **Please check box if private**

Telephone (home) _____ Telephone (work) _____

Mobile _____ Other _____

5. E-Mail _____

6. Occupation _____ Employer _____

Address _____

Please check Single Married Widowed Divorced Other

7. Name of Spouse _____ Employer _____

Address/Phone _____

8. Complete if under 18 years or a student

Name of Father _____ Employer _____

Name of Mother _____ Employer _____

9. Are you responsible for the payment of your fees? Yes No; who is? _____

10. Insurance Information (most procedures are not covered procedures with your insurance company)

Primary _____ Policy/Member # _____

Secondary _____ Policy/Member # _____

11. Whom to notify in emergency (nearest relative other than spouse)

Name _____ Relationship _____

Address _____

Home Phone _____ Work Phone _____

Authorization to release: I hereby authorize The Stern Center to furnish the insured's insurance company all information which said insurance company may request to process my claim.

Assignment of insurance benefits: I hereby assign to the doctor all money to which I am entitled for expense relative to the services performed, but not to exceed my indebtedness to The Stern Center. It is understood that any money received from the above named insurance company over and above my indebtedness will be either refunded to me or the insurance company, when my bill is paid in full. I understand I am financially responsible to The Stern Center for all charges.

Responsible Party's Signature

Patient's Signature

Date

Our **Notice of Privacy Practices** describes how your health information may be used and disclosed, and how you can access your information. **By my signature below, I acknowledge receipt of the Notice of Privacy Practices.**

Responsible Party's Signature

Patient's Signature

Date