Aesthetic Skin and Laser Medical Center
Patient Registration Form

Thank you for choosing our office! In order to serve you properly, we need the following PRINTED information. All information will be confidential.

PATIENT _____ ☐ **Male** ☐ **Female**
Last **First** **MI**

Date of Birth ____ /____ /_____ **Age** ____ **Social Security #** _____ **Drivers License #**_____

Home Address (No P.O. Boxes Please) _____

City_____ **State** _____ **ZIP** _____

Home Phone ( ) _____ - _____ **Cell** ( ) _____ - _____

*****Mailing Address (If different from above)** _____

City_____ **State** _____ **ZIP** _____

Email Address _____

Employer_____ **Occupation** _____

Business Address_____

Business Phone ( ) _____ - _____

Responsible Party _____ **Date of Birth** _____ /_____ /_____

Social Security # _____ **Employed by** _____

Business Phone ( ) _____ - _____ **Occupation**_____

Referred by _____

EMERGENCY CONTACT (Name of relative or friend, not living with you)

Name_____ **Relationship**_____ **Phone** ( ) _____ - _____

PRIMARY INSURANCE ***Please check this box if you have no insurance** ☐

Insurance Carrier _____ **Phone** ( ) _____ - _____

Address _____

Insurance ID _____ **Group/Plan** _____

Name of Insured _____**Relationship to Insured:** ☐ **Self** ☐ **Spouse** ☐ **Child**

Amount of Your Co-Pay $_____

SECONDARY INSURANCE

Insurance Carrier _____ **Phone** ( ) _____ - _____

Address _____

Insurance ID _____ **Group/Plan** _____

Name of Insured _____**Relationship to Insured:** ☐ **Self** ☐ **Spouse** ☐ **Child**

Amount of Your Co-Pay $_____

I, _____ **authorize Dr. Steven E. Hodgkin, MD and the High Desert Skin and Laser Medical Center to examine and provide medical treatment. I assume full responsibility for paying my insurance co-pay and/or deductible on the day the service is provided. I understand that I will receive a statement regarding any outstanding balance due after my insurance has paid their full amount. I understand timely remittance is expected and my account will be subject to collections if I fail to pay in full after 90 days. I authorize my insurance company to pay by check made out directly to Steven E. Hodgkin, MD or High Desert Skin and Laser Medical Center. I authorize High Desert Skin and Laser Medical Center to release/obtain any medical or incidental information that may be necessary for either medical care or in processing applications for financial benefit. I understand that my medical records will be maintained for 10 years, but may be destroyed after 10 years. I understand it is my responsibility to know all rules and restrictions of my insurance policy, to know which hospital, emergency rooms, laboratories, x-ray departments and specialists and specialist providers which are assigned to me according to my insurance policy rule. It is High Desert Skin and Laser Medical Center's procedure to share Protected Health Information with labs, x-rays, consulting physicians, and hospitals.**

_____ _____

Patient or Responsible Party Signature **Date**