

AESTHETIC LASER SURGERY & DERMATOLOGY, Ltd.
400 N. Main Street, Centerville, OH 45459 (937) 438-3376

PATIENT REGISTRATION FORM

***REQUIRED INFORMATION**

Last Name _____ First Name _____ Middle Initial _____

Street Address _____

City _____ State _____ Zip _____

Phone #1 _____ Phone #2 _____ Email: _____

Date of Birth _____ - _____ - _____ Age _____ Male _____ Female _____ Marital Status: S M W D

*Social Security Number _____ - _____ - _____

Employer or School _____ Work Phone _____

Occupation _____

How were you referred _____

Family Physician _____ Address _____ Phone _____

Specialist Physicians: 1. _____ 2. _____

3. _____ 4. _____

Nearest Relative or Friend _____ Home Phone _____

(not living with you)

PRIMARY INSURANCE _____ Effective Date _____

*Cardholder/Employee Name _____ *Date of Birth _____

Home Address _____

City _____ State _____ Zip _____ Home Phone _____

*Social Security Number _____ - _____ - _____

Employer _____ Work Phone _____

SECONDARY INSURANCE _____ Effective Date _____

*Cardholder/Employee Name _____ *Date of Birth _____

Home Address _____

City _____ State _____ Zip _____ Home Phone _____

*Social Security Number _____ - _____ - _____

Employer _____ Work Phone _____

PERSONAL MEDICAL INFORMATION

1. Please list the family members of significant others, if any, whom we may inform about your general medical condition and or your diagnosis: _____
2. Please print the address of where you would like your billing statements and/or correspondence from our office to be sent **if other than** your home: _____
3. Please print the telephone number, if any, where you want to receive calls about your appointments, lab, and x-ray results, or other health care information **if other than** your home phone: _____
4. Can confidential messages (i.e. appointment reminders) be left on your home answering machine or voicemail? yes no
5. If you do not have voice mail, can a confidential message be left at your place of employment: yes no

PATIENT NAME (please print) _____

PATIENT/GUARDIAN SIGNATURE _____ DATE _____

(guardian if patient is under 18 years)

We appreciate your cooperation in providing this information so that we may accurately correspond with insurance companies and laboratories. We protect all personal information.