REGISTRATION FORM

DATE ____________

PATIENT NAME: ____
First Name Middle Initial Last Name

ADDRESS: ____________________ CITY: __________ STATE: ______ ZIP: ________

PHONE-HOME: () __________ WORK: () __________ CELL:( ) __________

Which phone is best to contact you at? ○Home ○Work ○Cell

EMAIL ADDRESS: __________ DATE OF BIRTH: __________ SOCIAL SECURITY # ________

EMPLOYER: ____________________ EMPLOYER PHONE NUMBER: ( ) ________

EMPLOYER ADDRESS: ____________ CITY: __________ STATE: ______ ZIP: ________

MARITAL STATUS: ________ SPOUSE'S NAME AND PHONE: ____________________

MINOR - PARENT'S NAMES: ____________________ PHONE: ( ) ____________

EMERGENCY CONTACT: ______________ PHONE: ( )________ RELATIONSHIP: ____

PRIMARY CARE PHYSICIAN: ______________ REFERRING PHYSICIAN: ____________

HOW DID YOU HEAR ABOUT OUR OFFICE? ______________________________

PERSON RESPONSIBLE FOR BILL (Complete only if different from patient): ____________________

ADDRESS ______________ CITY ______________STATE ______ ZIP ________

RELATIONSHIP TO PATIENT ____________________ PHONE ____________________

SOCIAL SECURITY # ____________________ DATE OF BIRTH____________________

INSURANCE INFORMATION.(IF APPLICABLE)

Please present all cards (driver's license and insurance card) to receptionist for scanning.

PLAN NAME: ____________________ I.D. NUMBER: ______________

ADDRESS: ____________________ GROUP NUMBER: ______________

POLICY HOLDER: ____________________ EFFECTIVE DATE: ______________

I hereby assign directly to "Sholar Center for Aesthetic Surgery & Age Rejuvenation, LLC" all medical, surgical, and other benefits and proceeds payable under the insurance policy for services rendered to me by Sholar Center for Aesthetic Surgery & Age Rejuvenation. You are authorized to pay these benefits and proceeds to Sholar Center for Aesthetic Surgery & Age Rejuvenation.

I hereby authorize the release of any and all information necessary or required for the processing of claims under said insurance policy to my insurance carrier or any other necessary entity.

I understand and agree that I am personally responsible for all payments owed to Sholar Center for Aesthetic Surgery & Age Rejuvenation whether the services rendered are uninsured or deemed not medically necessary and not paid by my insurance. All payments are due at time of service, making any unpaid balances delinquent. I agree to pay all costs of collection including but not limited to third-party collection agency fees, reasonable attorney fees, court costs and allowable interest.

____________________ ____________________
Signature of Insurance Policyholder Date Signed

____________________ ____________________
Signature of Patient Date Signed

WRITTEN ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, ________________________, have received a copy of the Sholar Center for Aesthetic Surgery & Age Rejuvenation, LLC Notice of Privacy Practices.

____________________ ____________________
Signature of Patient Date Signed