

REGISTRATION FORM

PATIENT INFORMATION

Patient: First Name:		MI:	Last Name:	Date of Birth:
Birth Sex: <input type="checkbox"/> Female <input type="checkbox"/> Male		Gender Identity: <input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Transgender		
Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		Language Spoken: <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other		
Ethnicity: <input type="checkbox"/> Hispanic <input type="checkbox"/> Not Hispanic <input type="checkbox"/> Refused		Race: <input type="checkbox"/> White <input type="checkbox"/> Asian <input type="checkbox"/> Black <input type="checkbox"/> Hispanic <input type="checkbox"/> Indian/Native <input type="checkbox"/> Other <input type="checkbox"/> Refused		
Social Security #:		Phone #'s:		Preferred Phone:
Is the patient covered by insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No		Home:		Cell: Work:
		Mailing address:		
City:		State:	Zip Code:	
Email address:		Would you like to be added to our cosmetic/Aesthetic services E-mail list : <input type="checkbox"/> Yes <input type="checkbox"/> No		
Employer's Name:		Occupation:		

IN CASE OF EMERGENCY WHO WOULD YOU LIKE TO BE CONTACTED

Contact Full Name:			Relationship to patient:
Phone: Home	Cell	Work	

PARENT/GUARDIAN (REQUIRED IF PATIENT IS UNDER 21 YEARS)

NOTE: Per NC Law, Both Parents can be held responsible for medical bills for minors, a medical practice is **NOT** bound by any separation agreement, divorce or child support order.

Parent/Guardian: First:		MI:	Last:
Phone #:	Date of Birth:	Address (If Different): <input type="checkbox"/> Same as above	