

GENESIS COSMETIC SURGERY CENTER & MEDICAL SPA
PATIENT REGISTRATION

TODAY'S DATE _____ REFERRED BY _____ PRIMARY PHYSICIAN _____

PATIENT'S NAME _____

ADDRESS _____ *FIRST* _____ *M.I.* _____ *LAST* _____ APT# _____ CITY _____ ST _____ ZIP _____

HOME# (_____) _____ WORK# (_____) _____ CELL# (_____) _____

E-MAIL ADDRESS (if applicable) _____ HOME WORK

PATIENT'S SOCIAL SEC# _____ DATE OF BIRTH _____ MALE FEMALE

PATIENT'S EMPLOYER (if applicable) _____

ADDRESS _____ APT# _____ CITY _____ ST _____ ZIP _____

MARITAL STATUS: SINGLE MARRIED DIVORCED WIDOWED

SPOUSE'S NAME _____ PHONE# (_____) _____

SPOUSE'S EMPLOYER (if applicable) _____ *FIRST* _____ *M.I.* _____ *LAST* _____

ADDRESS _____ APT# _____ CITY _____ ST _____ ZIP _____

EMERGENCY CONTACT (if different from spouse) _____ PHONE# (_____) _____

COMPLETE IF PATIENT IS UNDER 18 YEARS OF AGE

FATHER'S NAME _____ SOCIAL SEC# _____

EMPLOYER _____ PHONE# (_____) _____

MOTHER'S NAME _____ SOCIAL SEC# _____

EMPLOYER _____ PHONE# (_____) _____

INSURANCE/FINANCIAL INFORMATION

PRIMARY INSURANCE CO _____ PHONE# (_____) _____

GROUP# _____ ID# _____

SUBSCRIBER'S NAME _____ DOB _____ SOCIAL SEC# _____

PATIENT'S RELATIONSHIP TO INSURED: SELF SPOUSE CHILD OTHER

SECONDARY INSURANCE CO _____ PHONE# (_____) _____

GROUP# _____ ID# _____

SUBSCRIBER'S NAME _____ DOB _____ SOCIAL SEC# _____

PATIENT'S RELATIONSHIP TO INSURED: SELF SPOUSE CHILD OTHER

ASSIGNMENT OF BENEFITS/RELEASE OF MEDICAL INFORMATION

I assign all medical benefits entitled to me to be paid to Genesis Medical Associates, P.C. I authorize the release of my medical records and any other information necessary for processing my claim. This assignment remains in effect until revoked in writing. A photocopy is as valid as the original. I understand that I am responsible for payment of all services. If Dr. Timothy Jones does not participate in my insurance, or my insurance denies payment for a non-covered insurance, I will be responsible for full payment of the billed services. If this is a cosmetic visit or self-pay, I understand that the initial visit is payable at the time of service. Patient due balances are payable within thirty (30) days and finance charges in the amount of 1 ½% per month will be assessed on past due accounts. I also agree to pay costs involved with the collection of delinquent accounts.

SIGNATURE _____ DATE _____
PATIENT/GUARDIAN

SIGNATURE _____ DATE _____
INSURED OR AUTHORIZED PERSON