REGISTRATION FORM

PATIENT INFORMATION

Patient: First Name:	MI:	Last Name:	Date of Birth:

Birth Sex: ☐ Female ☐ Male	Gender Identity: ☐ Female ☐ Male ☐ Transgender
Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced	Language Spoken: ☐ English ☐ Spanish ☐ Other
Ethnicity: ☐ Hispanic ☐ Not Hispanic ☐ Refused	Race: ☐ White ☐ Asian ☐ Black ☐ Hispanic ☐ Indian/Native ☐ Other ☐ Refused
Social Security #:	Phone #'s: Preferred Phone: Home: Cell: Work:
Is the patient covered by insurance? ☐ Yes ☐ No	

Mailing address:		APT #:
City:	State:	Zip Code:

Email address:	Would you like to be added to our cosmetic/Aesthetic services E-mail list : ☐ Yes ☐ 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/GAURADIAN (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): ☐ Same as above