

All information will be part of your confidential medical record

PATIENT REGISTRATION FORM

PLEASE COMPLETE ENTIRE FORM

PATIENT NAME: Last Name First Name Middle Name Suffix (Jr, Sr)
MAILING ADDRESS: Street or PO Box City State Zip
How Did You Hear About Us? (circle) Friend/Relative | Billboard | Print Ad | Web/Internet | Physician Referral | Other
****LAST 4 DIGITS SSN: SEX: M F RACE: BIRTH DATE: MM/DD/YYYY MAR STATUS: Mar Single Div Widow
HM Ph #: Wk #: CELL #:
EMAIL ADDRESS: OK TO RECEIVE EMAIL / TEXT NOTICES
PRIM CARE PHYSICIAN: SPOUSE NAME CELL#
COMPLETE THE FOLLOWING: RETIRED STAY-AT-HOME STUDENT UNEMPLOYED
PATIENT'S EMPLOYER: JOB TITLE:
Employer Address: Street or PO Box City State Zip
Required: EMERGENCY CONTACT (IF NOT SPOUSE AS NOTED ABOVE): RELATIONSHIP:
Contact Hm Ph #: Wk Ph#: Cell #:

*PLEASE PRESENT PHOTO ID AND PAYMENT DUE UPON CHECK-IN.

FINANCIALLY RESPONSIBLE PARTY (IF NOT PATIENT) SUCH AS PARENT/GUARDIAN/SPOUSE:
Full Name: Relationship:
Address: Street or PO Box City State Zip
Home Ph #: Work/Cell Ph #:
Date of Birth: MM/DD/YY Employer / Address:

PLEASE READ THIS ENTIRE SECTION AND SIGN BELOW

I, the undersigned, agree that I am responsible for all fees at the time of service unless other arrangements have been made in advance. I agree to remit payment for office visit fees, procedure fees, and any and all other charges prior to treatment or upon request of such payment. I understand that this provider does not contract with health insurance, but rather offers private patient contracts with discounted self-pay rates. I acknowledge that any charges by this practice are separate from my health insurance, and that I will not attempt to seek reimbursement from my insurance once I have agreed to pay this physician directly on a self-pay basis. I acknowledge that any returned checks and past due balances may be subject to collection fees and interest charges, and that I may be charged for "no show" appointments if not cancelled 24 hrs in advance. I grant permission for release of my private health information with regard to any billing disputes to my credit card company, bank, manufacturers or other institution as deemed necessary to document services rendered.

I, the undersigned, hereby authorize and give consent to Dr. Barbara E. Howard and/or staff to administer such treatments and to perform such procedures as presented to and agreed upon by me. I grant permission for the use of my records in medical treatment, testing, device tracking, loyalty or rewards programs, credentialing, quality assurance, peer review and/or certifying purposes by those required to review such information including designated medical personnel, manufacturers of medical products and devices, the American Board of Plastic Surgery and the AAAASF Accreditation Board. (This form does not grant specific permission for use of the patient's photos for marketing purposes or releasing of private information to outside parties other than those noted herein or otherwise agreed to.)

SIGNATURE (patient/guardian): DATE: