INFINITY skin care

2019 Patient Registration Form

Patient Information Today's Date:_____

Name: _____ Sex ❒M ❒ F
First *Middle* *Last*

Prefer to be called:_____ Title: ❒Mr. ❒Mrs. ❒Ms. ❒Miss ❒Dr.

Date of Birth:_____/_____/_____ Age_____ Employer:_____
Month Day Year

Patient's Address:_____
Street # *Street Name* *Apt #*

_____
City *State* *Zip*

Home Phone:_____ Cell Phone:_____
Area code *Area Code*

Work Phone:_____ Email: _____
Area code

Which phone would you prefer us to call? ❒ Home ❒ Cell ❒ Work

Parent or Responsible Party (if patient is a minor)

Name: _____ Sex ❒ M ❒ F
First *Middle* *Last*

Date of Birth:_____/_____/_____ Age_____ Employer:_____
Month Day Year

Address:_____
Street # *Street Name* *Apt #*

_____
City *State* *Zip*

Home Phone:_____Cell Phone:_____Work Phone:_____
Area code *Area Code* *Area Code*

How did you hear about us?_____ Pharmacy of Choice _____

Do we have your permission to:	Yes	No
Leave a message on your cell phone?	❒	❒
Leave a message on your home phone?	❒	❒
Leave a message at your place of employment?	❒	❒
Discuss your treatment with any member of your household?	❒	❒

If yes, whom?_____ Relationship_____

×_____ _____
Signature of Patient or Responsible Party *Date*

Continued on Reverse Side

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****Please Sign This Side Of Form At The Time Of Registration****

Privacy Policy:

I understand that as part of my healthcare, *Infinity Skin Care / Infinity Vein Center* originates and maintains health records describing my health history, symptoms, examination, and treatment, and plans for future care or treatment. I understand that this information serves as a basis for planning my care and treatment. All patient medical records and photographs are kept strictly confidential and are never disclosed to anyone for any reason unless specifically requested or authorized in writing by the patient.

I understand and have been provided with a ***Notice of Privacy Practices*** that provides a more complete description of information uses and disclosures.

Signature of patient or responsible party: ×_____ Date:_____

Witness:_____ Date:_____

Payment Policy:

In order to establish optimal relations with our patients and avoid misunderstanding regarding our payment policies, our staff is trained to inform you of the financial policies of this office. **Full payment is expected from you at the time of service. We accept cash, check, Visa, Mastercard, American Express and Discover for your convenience.** Your signature below indicates that you understand and accept this policy.

Signature of patient or responsible party: ×_____ Date:_____