DR. LEE B. DANIEL
AESTHETIC PLASTIC SURGERY • THE SPA SIDE

PATIENT REGISTRATION

*(Please fill out form with **BLACK** Ink)* **~ SIGN & DATE AT BOTTOM**

Reason for visit: _____ *Referred by*: _____
Primary Physician: _____ *Phone*: _____

First Name: _____ *MI*: ____ *Last Name*: _____ *DOB*: _____ *Age*: _____

Gender: Female | Male *Marital Status*: S M D W

Mailing Address: _____ *City*: _____ *State*: _____ *Zip*: _____

Okay to Receive Mail at Address Listed Above?: Yes | No

Home #: _____ *Cell*: _____ *Work*: _____
Email Address: _____ *Receive Specials via Email*: Yes No
Preferred Contact Method: Home Number | Mobile Number | Text | Email
Are You Interested In Monthly Payments (Financing)?: Yes No

SSN: _____ *Driver's License*: _____
Employer or School: _____ *Occupation*: _____
Address: _____ *City*: _____ *State*: _____ *Zip*: _____

Responsible Party (if patient is a minor): _____ *Telephone*: _____
Mailing Address: _____ *City*: _____ *State*: _____ *Zip*: _____
Telephone Home: _____ *Cell*: _____ *Work*: _____

Spouse/Partner: _____ *Date of Birth*: _____
Mailing Address: _____ *City*: _____ *State*: _____ *Zip*: _____
Telephone Home: _____ *Cell*: _____ *Work*: _____
Email Address: _____ *Employer*: _____

INSURANCE INFORMATION - COMPLETE THIS SECTION IF WE ARE BILLING INSURANCE

[Cosmetic Procedures are Elective and WILL NOT be Billed to Insurance]

Primary Insurance: _____
ID#: _____
Group #: _____
Subscriber: _____ DOB: _____
Group Name: _____

Secondary Insurance: _____
ID#: _____
Group #: _____
Subscriber: _____DOB: _____
Group Name: _____

Insurance is billed as a courtesy to our patients. Please provide us with complete and current information. We cannot accept responsibility for collecting an insurance claim or for negotiating a disputed claim. Insurance benefits and reimbursement are a contract between you, your employer and/or the insurance company. You are responsible for your account. If your insurance requires you to make co-payments or to pay a percentage of the allowable amount, such payment is required at the time of service. I agree to assign all insurance payments received to Dr. Daniel for services performed and I understand that, regardless of any insurance coverage, I am responsible for payment of my account.

_____ _____

Patient or Responsible Party Signature ***Date***