Lavers Center
for Advanced Aesthetics

PATIENT REGISTRATION

Date: _____

Patient Name: _____
First Last MI

Preferred Name: _____ DOB: _____ Gender:_____

Address: _____

City: _____ State: _____ ZIP: _____

Cell #:_____ Email:_____

Primary Care Physician: _____ Pharmacy: _____

Occupation: _____ Employer: _____

How did you hear about us? _____

If under age 18, please complete information below:

Legal Guardian's Name: _____ Relationship: _____

EMERGENCY CONTACT INFORMATION

Name: _____ Relation: _____ Phone #: _____

PAYMENT AGREEMENT

Payment is due in full at the time of service. Lavers Center for Advanced Aesthetics does not accept insurance.

HIPPA REQUIREMENT

□ I have been given a copy of the Notice of Privacy Practices for Lavers Center for Advanced Aesthetics
□ I do not require a copy of the Notice of Privacy Practices for Lavers Center for Advanced Aesthetics

PROMOTIONAL MARKETING PERMISSION

□ I give my permission to receive email promotional materials from Lavers Center for Advanced Aesthetics
□ I give my permission to receive text promotional materials from Lavers Center for Advanced Aesthetics

APPOINTMENT & CANCELLATION POLICY

□ I have been given a copy of the Appointment and Cancellation Policy for Lavers Center for Advanced Aesthetics

By signing below, I agree that all the above information is accurate and if at any time this information has changed, I will inform Lavers Center of Advanced Aesthetics staff. I also agree to the Payment Policy and Appointment and Cancellation Policy stated above.

_____

Patient/Legal Guardian's Signature