PATIENT REGISTRATION

Date: ____________________

Patient Name: ____
First Last MI

Preferred Name: ______________________ DOB: ______________ Gender: __________

Address: ____

City: ______________________ State: __________ ZIP: ______________

Cell #: ______________________ Email: ______________________________

Employer: ______________________ Occupation: ______________________

Primary Care Physician: ______________________ Pharmacy: ______________________

How did you hear about us? ______________________________________

If under age 18, please complete information below:

Legal Guardian's Name: ______________________ Relationship: ______________

EMERGENCY CONTACT INFORMATION

Name: ______________________________ Phone #: ______________________

Relationship to Patient: ______________________

PAYMENT AGREEMENT

Payment is due in full at the time of service. Lavers Aesthetics is a cash pay only clinic and does not accept insurance.

□ **I have been given a copy of the Notice of Privacy Practices for Lavers Aesthetics**

□ **I do not require a copy of the Notice of Privacy Practices for Lavers 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 Aesthetics staff.

I also agree to the Payment Agreement as stated above.

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Patient/Legal Guardian's Signature