CHICAGO
COSMETIC SURGERY & DERMATOLOGY

REGISTRATION FORM

PATIENT INFORMATION:						DATE:
LAST NAME:	FIRST NAME:	MI:		BIRTHDATE:		GENDER:
HOME ADDRESS:	APT#/SUITE			CITY:	STATE:	ZIP:
HOME #:	MOBILE #:	WORK #:	EMAIL:			PRONOUNS:

RACE: ***OR CHECK BOX:*** Declines to provide ☐ Hispanic ☐ Black/African American ☐ Asian ☐ American Indian ☐ Alaskan Native ☐ Native Hawaiian Pacific Islander ☐ White ☐ Other ☐	ETHINICITY: ***OR CHECK BOX*** Hispanic/Latino ☐ Not Hispanic/Latino Other ☐ Declines to provide ☐
LANGUAGE:	MARITAL STATUS:
REFERRAL SOURCE: ***OR CHECK BOX:*** CCSD website ☐ Insurance ☐ Google ☐ Yelp ☐ CS Magazine ☐ RealSelf ☐ Current Patient ☐ Please specify:	PRACTICE REMINDERS: I want to receive text message appointment reminders; I Agree ☐ I Disagree ☐ I want to receive email appointment reminders and newsletters; I Agree ☐ I Disagree ☐
PRIMARY CARE PHYSICIAN: / TEL #:	VOICEMAIL MESSAGES: Do you give permission for CCSD to leave detailed messages on your phone regarding prescription refills, test results and treatment information?
REFERRING PHYSICIAN: / TEL#:	

EMERGENCY CONTACT INFORMATION			
NEXT-OF-KIN FIRST NAME:	NEXT-OF-KIN LAST NAME:	RELATIONSHIP:	
HOME #:	CELL OR WORK #:		

INSURANCE INFORMATION – ***In order for claims to be billed to insurance, current information must be presented at each***				
PRIMARY INSURANCE PROVIDER:	PRIMARY GROUP NUMBER:	PRIMARY IDENTIFICATION NUMBER:		
NOTE: Complete the portion if policy holder is other than the patient.				
FIRST NAME:	LAST NAME:	GENDER:	RELATIONSHIP:	BIRTHDATE:
Is the policy holder a patient at Chicago Cosmetic Surgery and Dermatology? YES ☐ NO ☐				

SECONDARY INSURANCE PROVIDER:	SECONDARY GROUP NUMBER:	SECONDARY IDENTIFICATION NUMBER:		
NOTE: Complete the portion if policy holder is other than the patient.				
FIRST NAME:	LAST NAME:	GENDER:	RELATIONSHIP:	BIRTHDATE:
Is the policy holder a patient at Chicago Cosmetic Surgery and Dermatology? YES ☐ NO ☐				

Who should receive billing statements? SELF ☐ POLICY HOLDER ☐

X _____ **Date:** _____

Patient Signature or Signature of Guardian or Parent

RECORDS RELEASE & CONSENT TO TREAT:

I authorize the release of any necessary medical information for the purpose of processing claims with my insurance company, pharmacy requests and authorizations, and anything pertinent to my care. I permit a copy of this authorization to be used in place of the original. By signing this form, I authorize the physicians and employees of Chicago Cosmetic Surgery and Dermatology to provide medical or surgical care and services. In the course of my medical care, I agree to comply with the plan of care/services to which I have consented.

X_____ **Contact#:**_____

Guardian or Parent Name