

REJUVENATA

HEALTH & AESTHETICS

8390 E. Via de Ventura, Suite F-111 | Scottsdale, AZ 85258 | phone 480.951.0111 | fax 480.951.6505

New Patient Registration

Date: _____

Patient Name: _____ SSN: _____

Age: _____ Sex: M _____ F _____ Date of Birth: _____

Phone: Home _____ Work _____

E-Mail address: _____

Address: _____

City: _____ State: _____ Zip code: _____

Spouses name: _____

Employer: _____ Phone: _____

Employment status: Full time _____ Part time _____ Retired _____ Not employed _____

Retirement date: _____

Spouses Employer: _____ Phone: _____

Employment status: Full time _____ Part time _____ Retired _____ Not employed _____

Retirement date: _____

Signature on file (medicare only): Y _____ N _____

Primary Insurance carrier: _____

Primary Insured name: _____

Policy #: _____ Group #: _____

Relationship to insured: Self _____ Spouse _____ Child _____ Other _____

Signature on file (medicare only): Y _____ N _____

Primary Insurance carrier: _____

Primary Insured name: _____

Policy #: _____ Group #: _____

Signature on file (medicare only): Y _____ N _____

Secondary Insurance carrier: _____

Secondary Insured name: _____

Policy #: _____ Group #: _____

Whom should we notify in case of emergency:

Name: _____ Phone: _____

Address: _____

I understand that I am financially responsible for payment of this account and/or charges not covered by my insurance.

Signature: _____