Skin Diagnostics Laser & Rejuvenation

Beatriz H. Porras, M.D.
9201 Montgomery Road
Cincinnati, OH 45242
Phone: 513.631.0059/Fax: 513.631.0068

Patient Registration

Date: _____

Patient Name: **LAST:** _____ **FIRST:** _____

Date of Birth: _____ Social Security #: _____

Address: _____

City: _____ State: _____ Zip: _____ Email: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Gender: (Circle) M F Race: _____ Marital Status: (Circle) S M D W

Employer: _____ Occupation: _____

Emergency Contact: _____ Phone #: _____

Primary Care Physician: _____ Phone #: _____

Insurance Information: This information is not needed for cosmetic patients.

Primary Insurance: _____ Phone #: _____

Primary Subscriber: _____ Relation to Patient: _____

Subscriber DOB: _____ SSN: _____ Gender: M F

Policy ID #: _____ Group #: _____

Secondary Insurance: _____ Phone #: _____

Primary Subscriber: _____ Relation to Patient: _____

Subscriber DOB: _____ SSN: _____ Gender: M F

Policy ID #: _____ Group #: _____

Please Read and Sign to Give Consent:

I understand that medical treatment may be necessary. I hereby consent to the administration of all diagnostic and/or therapeutic treatments that may be considered advisable or necessary in the physician's judgment. I authorize the physician to the release of minimal, necessary information acquired during my examination or treatment to insurance carriers, Medicare and its agents, or others in accordance with State and Federal privacy rules. I hereby authorize that benefits from insurance carriers and Medicare be paid directly to Skin Diagnostics/Dr. Beatriz Porras.

I acknowledge that I am responsible for payment to Dr. Beatriz Porras, Skin Diagnostics for services rendered. I am responsible for making sure Dr. Beatriz Porras in a participating physician in my insurance carriers plan. I am responsible for any services not covered by my health benefits plan, including but not limited to: co-payments and deductibles. If I don't call to cancel a scheduled appointment at least 24 hours in advance, I will be billed $50 and I am responsible for that payment.

Signature: _____ **Date:** _____

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Patient History

Last_____First_____DOB_____Race:_____Sex:_____

Occupation_____Age____How did you hear about us? _____

Referred by: _____Primary Care Physician: _____

Pharmacy Information: Name_____Zip Code_____Phone #_____

Chief Skin Complaint:_____

Location on Body: _____ Duration of Condition: _____

Previous Treatments for this Condition:_____

_____

Past Personal Medical History:_____

_____

Family History: _____

_____

Current Medications: _____

_____ _____

Allergies: _____

_____

Please write any other personal information you consider important:_____

_____

_____