PATIENT REGISTRATION FORM

Welcome to our practice. We are delighted that you are here. Please take a brief moment and fill out the following registration form. This information is for your *confidential* file.

Name: _____ Date of Birth: _____ Age _____
Last Name First Name Middle

Address: _____
Street City State Zip

Social Security Number: _____ Married Single Divorced Widowed

Phone: Home _____ Cell _____

Work _____

Email _____ Contact by Email ____ yes ____ no

Employer: _____ Occupation: _____

Spouse's Name: _____ Employer: _____

In order to protect your privacy, please indicate if we are permitted to send correspondence or call you at the above address and phone numbers.

_____Yes, please use the above address and phone number (s) to contact me

_____No, please contact me at: _____

How did you find us?

Phone book:	__Qwest - Eastside	Qwest – Seattle ___
	__Verizon - Eastside	Verizon - Seattle___
Internet:	_____Site	Dr. Sanderson's Web Page___
Doctor:	_____	
Friend:	_____	Other Referral_____

In case of emergency, local friend or relative to be notified:
Name: _____ Relationship to Patient: _____

Home Phone: _____ Work Phone: _____

OUR COMMITMENT TO YOUR PRIVACY

Our practice is dedicated to maintaining the privacy of your individually identifiable health information. In conducting our business, we will create records regarding you and the treatment and services we provide to you. We are required by law to maintain the confidentiality of health information that identifies you. We also are required by law to provide you with this notice of our legal duties and the privacy practices we maintain in our practice concerning your IIHI. By federal and state law, we must follow the terms of the notice of privacy practices that we have in effect at the time. **OUR NOTICE OF PRIVACY PRACTICES IS AVAILABLE FOR YOUR REVIEW IN OUR OFFICE, OR YOU MAY REQUEST A COPY.**

My signature below indicates I have been informed about the privacy practices of your office and I will request a copy if I have any questions. I consent to a plastic surgery consultation and examination and/or treatment by Dr. Aysel K. Sanderson.

_____ _____
Patient Signature Date

Insurance Information: This office is not a participating provider for any insurance plans. We will need a copy of your insurance card, *if* you feel you could be reimbursed for non-cosmetic surgery.