

PATIENT REGISTRATION

Robin A. Sykes, M.D.

Name _____ Last First MI	I prefer to be called _____	<input type="checkbox"/> Male	<input type="checkbox"/> Female
SSN _____	Date of Birth _____	Age _____	<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed

Local Address
_____ Street
_____ City State Zip
Home Phone () _____
Work Phone () _____
Cell Phone () _____



Email _____

Please give us your email address so we can notify you of our special offers and receive our newsletters.

Alternate Address
_____ Street
_____ City State Zip
Alternate Phone () _____

Referred by: (CHECK ALL THAT APPLY)

- | | |
|---|---|
| <input type="checkbox"/> Physician: _____ | <input type="checkbox"/> Jupiter Plastic Surgery Center Website |
| <input type="checkbox"/> Family/Friend: _____ | <input type="checkbox"/> Google or other search engine |
| <input type="checkbox"/> Newspaper | <input type="checkbox"/> Looking Your Best.com |
| <input type="checkbox"/> Seminar | <input type="checkbox"/> Internet Other: _____ |
| <input type="checkbox"/> Other: _____ | <input type="checkbox"/> Yellow Pages |

Emergency Contact Information

Name _____	Relationship _____	Phone () _____
Address _____	Street City State Zip	

Spouse Information

Name _____	Date of Birth _____
Employer _____	Phone () _____

Guarantor Information

Name _____	Relationship _____	Phone () _____
Address _____	Street City State Zip	

Insurance Information

Primary Insurance Company Name _____

Secondary Insurance Company Name _____

Insurance is considered a method of reimbursing the patient for fees paid to a physician and is not a substitute for payment. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. It is the patient's responsibility to pay any deductible amount, coinsurance, or any other balance not paid for by your insurance

To the extent necessary to determine liability for payment and to obtain reimbursement, I authorize disclosure of portions of my medical record. I hereby assign all medical and/or surgical benefits to include major medical benefits to which I am entitled including Medicare, private insurance, and other health plans to ROBIN A. SYKES, M.D.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize said assignee to release all information necessary to secure payment.

Signature _____ Date _____