REVITALIZE
PLASTIC SURGERY & MEDICAL SPA

REGISTRATION FORM

GENERAL INFORMATION					
Last Name		First Name			M.I.
Preferred Name (if different from above)				Marital Status: S M W D	
Home Address		City		State	Zip Code
Last 4 Digits of SS #	Birth Date	Age	Gender	Preferred Pronouns	
Cell Phone #	Home Phone #	Email Address			
Would you like to receive office specials to email listed above? ☐ Y ☐ N					
Spouse's Name		Spouse's Phone #			

EMERGENCY CONTACT – Who should we contact in case of an emergency – OTHER than your home?		
Name	Relationship	Phone #

REFERRAL INFORMATION		
How did you hear about our office? ☐ INTERNET ☐ SOCIAL MEDIA ☐ PATIENT ☐ OTHER: _____		
May we thank them?	Name and Address	Phone #
☐ Y ☐ N		

Complete the following if you are <u>not</u> a Spa-only patient:

EMPLOYMENT INFORMATION			
PATIENT'S Employer		Occupation	
Address, City, State, Zip		Phone #	
	PRIMARY INSURANCE:	SECONDARY INSURANCE:	
Insurance Company Name			
Subscriber ID			
Group Number			
Subscriber Name			
Subscriber Date of Birth			
Subscriber Employer			

PRIMARY CARE PHYSICIAN INFORMATION		
Primary Care Physician:	Address:	Phone #

PREFERRED PHARMACY		
Pharmacy Name:	Address:	Phone #:

I certify that the above information is correct to the best of my knowledge. I will not hold Revitalize Plastic Surgery and Medical Spa and their providers responsible for any omissions/errors I have made in completing this form.

Patient Signature: _____ Date: _____