Patient Registration

Welcome to ***The Stern Center for Aesthetic Surgery, P.C.*** Please complete this form and return it to the receptionist, who will use the information to prepare your chart, or mail to:
The Stern Center for Aesthetic Surgery, PC, 1370 116th Avenue NE, Suite 102, Bellevue, WA 98004

PLEASE PRINT How were you referred? _____

If an individual referred you, may we send a thank you letter? _____

1. Name _____ Date_____
2. _____
   Address City State Zip
3. Date of Birth _____ Age_____ Male/Female (Circle One)
4. Social Security # (Optional)_____
5. **Please check box if private**
   Telephone (home) _____ Telephone (work) _____
   Mobile _____ Other_____
6. E-Mail (Optional)_____
7. Occupation _____ Employer_____
   Address _____
   Please check □ Single □ Married □ Widowed □ Divorced □ Other
8. Name of Spouse_____ Employer_____
   Address/Phone _____
9. Complete if under 18 years or a student
   Name of Father _____ Employer_____
   Address/Phone _____
   Name of Mother_____ Employer_____
   Address/Phone _____
10. Are you responsible for the payment of your fees? □ Yes □ No; who is?_____
11. Insurance Information
    □ Primary _____ Policy/Member #_____
    □ Secondary _____ Policy/Member #_____
12. Whom to notify in emergency (nearest relative other then spouse)
    Name _____ Relationship _____
    Address _____
    Home Phone _____ Work Phone _____

Authorization to release: I hereby authorize The Stern Center to furnish the insured's insurance company all information which Said insurance company may request to process my claim.

Assignment of insurance benefits: I hereby assign to the doctor all money to which I am entitled for expense relative to the services performed, but not to exceed my indebtedness to The Stern Center. It is understood that any money received from the above named insurance company over and above my indebtedness will be either refunded to me or the insurance company, when my bill is paid in full. I understand I am financially responsible to The Stern Center for all charges.

Responsible Party's Signature Patient's Signature Date

Our **Notice of Privacy Practices** describes how your health information may be used and disclosed, and how you can access your information. **By my signature below, I acknowledge receipt of the Notice of Privacy Practices.**

Responsible Party's Signature Patient's Signature Date