c h i c a g o
COSMETIC SURGERY AND DERMATOLOGY

REGISTRATION FORM

PATIENT INFORMATION: Patient ID					DATE:
LAST NAME:	FIRST NAME:	MI:	BIRTHDATE:		GENDER:
HOME ADDRESS:	APT#/SUITE		CITY:	STATE:	ZIP:
HOME #:	MOBILE #:	WORK #:	EMAIL:		PREFERRED CONTACT:

RACE:
OR CHECK BOX:
Hispanic ☐ Black/African American ☐ Asian ☐ American Indian ☐
Alaskan Native ☐ Native Hawaiian Pacific Islander ☐ White ☐ Other ☐
Declines to provide ☐

ETHINICITY:
OR CHECK BOX
Hispanic/Latino ☐ Not Hispanic/Latino Other ☐
Declines to provide ☐

LANGUAGE:

MARITAL STATUS:

REFERRAL SOURCE:
OR CHECK BOX:
CCSD website ☐ Insurance ☐ Google ☐ Yelp ☐ CS Magazine ☐ RealSelf ☐

Current Patient ☐ Please specify: ……

Other/Event ☐ Please specify: ……

PRACTICE REMINDERS:
receive newsletters about promotions and Practice information:
I Agree ☐ I Disagree ☐

Receive appointment reminders via Text ☐ Email ☐ Voice mail ☐:
I Agree ☐ I Disagree ☐

PRIMARY CARE PHYSICIAN:	TEL #:
REFERRING PHYSICIAN:	TEL#:

VOICEMAIL MESSAGES:
Do you give permission for CCSD to leave detailed messages on your phone regarding prescription refills, test results and treatment information?

EMERGENCY CONTACT INFORMATION

NEXT-OF-KIN FIRST NAME:	NEXT-OF-KIN LAST NAME:	RELATIONSHIP:
HOME #:	CELL OR WORK #:	

INSURANCE INFORMATION – *In order for claims to be billed to insurance, current information must be presented at each visit*

PRIMARY INSURANCE PROVIDER:	PRIMARY GROUP NUMBER:	PRIMARY IDENTIFICATION NUMBER:

NOTE: Complete the portion below only if different to patient

FIRST NAME:	LAST NAME:	GENDER:	RELATIONSHIP:	BIRTHDATE:

Is the policy holder a patient at Chicago Cosmetic Surgery and Dermatology? YES ☐ NO ☐

SECONDARY INSURANCE PROVIDER:	SECONDARY GROUP NUMBER:	SECONDARY IDENTIFICATION NUMBER:

NOTE: Complete the portion below only if different to patient

FIRST NAME:	LAST NAME:	GENDER:	RELATIONSHIP:	BIRTHDATE:

Is the policy holder a patient at Chicago Cosmetic Surgery and Dermatology? YES ☐ NO ☐

Who should receive billing statements? SELF ☐ POLICY HOLDER ☐

RECORDS RELEASE & CONSENT TO TREAT:

I authorize the release of any necessary medical information for the purpose of processing claims with my insurance company, pharmacy requests and authorizations, and anything pertinent to my care. I permit a copy of this authorization to be used in place of the original. By signing this form, I authorize the physicians and employees of Chicago Cosmetic Surgery and Dermatology to provide medical or surgical care and services. In the course of my medical care, I agree to comply with the plan of care/services to which I have consented.

X_____ **Date:**_____

Patient Signature or Signature of Guardian or Parent

X_____ **Contact#:**_____

Guardian or Parent Name