WEISS
Cosmetic & Laser Procedures

360 San Miguel Drive, Suite 403, Newport Beach, CA 92660
T:949-720-1400 F:949-720-1457 www.drweiss.com

NEW PATIENT REGISTRATION FORM

DATE:_____ **REASON FOR VISIT:**_____

E-MAIL: _____ **Sex:** M / F **Age:** **DOB:** _____

WORK ( )

PATIENT NAME: _____ **CELL PH** ( )

HM PH ( )

Name of person legally responsible:

(if patient is a minor, name of parent, Guardian,etc)

HOME ADDRESS: _____
STREET

CITY STATE ZIP

SOCIAL SECURITY # **DRIVERS LICENSE #**

How will you be paying for today's visit? **Cash - Check - Credit - Insurance -Cosmetic Consult**
If Insurance-Copay/Deductible payment may be required

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Primary Insurance Co:
(Please show Card to Receptionist)

Secondary:
(Please show Card to Receptionist)

How were you referred to Dr. Weiss?

- ❑ Insurance Company
- ❑ Other (**please specify**):
- ❑ Patient (first & last name):
- ❑ Physician (Name & Address or Phone #):
- ❑ Advertisement (**please specify**):

What treatments / services are you interested in?

- ❑ Cosmetic Surgery
- ❑ General Ophthalmology
- ❑ Fraxel
- ❑ Laser Skin Resurfacing
- ❑ Botox
- ❑ Collagen
- ❑ Restylane, Juvederm, Cosmoderm, Cosmoplast
- ❑ Chemical Peels
- ❑ Acne Scars
- ❑ Skin Care / Products

How much do you know about these procedures?

- ❑ Little or nothing
- ❑ I've been researching for over 6 months
- ❑ I know someone who has had this procedure
- ❑ Enough to start / have treatment done

How soon would you consider having a procedure?

- ❑ I am ready to start immediately
- ❑ 1 month
- ❑ 2-3 months
- ❑ 3-6 months
- ❑ not sure

MEDICAL PROBLEMS: (CHECK ALL THAT APPLY)

❑HEART ❑LUNG ❑DIABETES ❑THYROID ❑HYPERTENSION ❑SHORTNESS OF BREATH

DETAILS:_____

OTHER:_____

ALLERGIES:_____

CURRENT MEDICATIONS:_____

FINANCIAL RESPONSIBILITY

I am responsible for all financial obligations for health services provided to the above patient. If for any reason the account should become delinquent, I agree to pay for all rebilling charges, collection costs and reasonable legal fees. All cosmetic procedures MUST be paid in full prior to the procedure date. All other account balances must be paid in full within 30 days of receiving a statement. Any delinquent accounts will be subjected to a $10.00 rebilling fee, per billing cycle. For your convenience, we accept Visa, MasterCard and AMEX and have financing available. Please note that Refraction Examinations are not covered by insurance and are paid at the time of your visit. I have read and understand the Health Insurance Portability & Accountability (HIPPA) information.

_____ _____

Signature of Responsible Party Date

ASSIGNMENT OF BENEFITS AND RELEASE

I authorize the release of medical information necessary to process my insurance claims on my behalf. I hereby authorize my insurance benefits be paid directly to Richard A. Weiss, MD for services provided to me. A copy of this authorization shall be considered as valid as the original.

_____ _____

Signature of Responsible Party Date

PATIENT EMPLOYED BY:_____ **OCCUPATION:**_____

BUSINESS ADDRESS: _____ **BUS** _____

STREET CITY ZIP

NAME OF SPOUSE: _____

FIRST MIDDLE LAST

SPOUSE SOCIAL SECURITY #: _____ **DOB:**_____

SPOUSE EMPLOYED BY: _____ **OCCUPATION:** _____

❑I authorize Weiss Cosmetic & Laser Procedures to take a picture of me for identification purposes only. I do not authorize my photos for use in any marketing or advertising materials.

❑**I authorize Weiss Cosmetic & Laser Procedures to use my photos / videos' as testimonials for use in web based and printed marketing/advertising materials.**

_____ _____

Signature **Date**