Central Carolina Skin & Dermatology Center P.A.

Central Carolina Medi Spa

Dr. Ana Benitez-Graham

Patient Registration Form

Name: _____ SS#: _____ /_____ /_____

Phone: _____ Cell Phone: _____ Work Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Date of Birth: _____ / _____ / _____ Age: _____ Marital Status: _____ Race: _____ Male / Female

Employer Name: _____ E-mail Address: _____

(Please provide this information so that we may provide you access to your patient portal)

Parent/Guardian Name if Minor: _____

Phone: _____ Cell Phone: _____ Work Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Date of Birth: _____ / _____ / _____ Age: _____ Social Security #: _____ -_____ -_____

(Please provide a copy of your current primary and secondary insurance cards)

Did a health care provider refer you? If yes, whom? _____

Do you have a cosmetic/anti-aging concern? YES or NO

Have you ever had an in-office cosmetic treatment or used medical grade skincare in the past? YES or NO

Would you be interested in hearing more about the anti-aging solutions we offer in our practice? YES or NO

Do we have permission for the following:

~ Leave a message at your home phone? Y N At your work number? Y N At your cell number? Y N

~ Discuss your medical condition(s) with a member of your household/family? Y N

If yes, whom and contact number: _____

I hereby authorize payment of medical benefits to the clinician. I understand that insurance is a method of reimbursing the patient for fees paid to the clinician and is not a substitute for payment. I acknowledge that I am responsible for all copays, coinsurance, deductibles and non-covered services at the time of service.

Patient Signature: _____ Date: _____