

### PATIENT REGISTRATION

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home #: \_\_\_\_\_  Cell # \_\_\_\_\_  Work #: \_\_\_\_\_

**\*\*Please indicate your preference for a contact number by checking the appropriate box\*\***

Email Address: \_\_\_\_\_

**\*\*May we contact you by email? \_\_\_\_\_ Yes \_\_\_\_\_ No**

Driver's License Number: \_\_\_\_\_ Exp. Date: \_\_\_\_\_

Emergency Contact Name and Phone: \_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_

### PATIENT EMPLOYER INFORMATION

Employer's Name: \_\_\_\_\_ Occupation: \_\_\_\_\_

### STATEMENT OF FINANCIAL RESPONSIBILITY

I understand and agree that the cosmetic services provided by Dr. Prasad and Laser Esthetica Medical Associates are elective in nature and not covered by medical insurances. Therefore, payments are due in full at the time the services are rendered. Because of the elective nature of these treatments, I understand that there is a no refund policy for any services or treatments rendered.

Because each appointment time is reserved for me and therefore cannot be used for another client, there may be a \$50.00 charge for missed appointments unless I cancel two business days in advance.

I further understand that there is a \$25.00 charge for any returned checks. By signing this statement, I agree to the terms above.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date