

The
Cosmetic
Vein & Laser
Center

• Cosmetic Laser Surgery • Cosmetic Dermatology • Spider and Varicose Vein Treatment

PATIENT REGISTRATION FORM

Patient's Name: Last: _____ First: _____ MI: _____ Date: _____

Nickname: _____ Date of Birth: _____ SS No. _____ - _____ - _____

Address: _____

City: _____ State: _____ Zip Code: _____

Current Age: _____ Gender: M / F Marital Status: M / S / D / W Email: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Preferred Contact: _____ Home _____ Cell _____ Work

Employer: _____ Occupation: _____

Primary Physician: _____ Location: _____ Phone: _____

Pharmacy: _____ Phone: _____

Spouse Name: _____ Spouse Date of Birth: _____

Spouse SS No. _____ - _____ - _____ Employer _____ Work Phone: _____

Emergency Contact: _____ Relationship to Patient: _____ Phone: _____

Referred By: _____

Please tell us the reason for your visit here today: _____

How did you learn of our practice?: _____

PLEASE CHECK SERVICES YOU WOULD LIKE MORE INFORMATION ABOUT:

FACIAL REJUVENATION

- Laser Resurfacing
- Botox & Cosmetic Fillers
- Microdermabrasion
- Glycolic Fruit Acids
- Photo Facial - Intense Pulsed Light
- Fraxel Laser Wrinkle Treatment
- Thermage Skin Tightening
- Photodynamic Therapy

LASER TREATMENTS

- Hair Removal
- Brown Spots / Age spots
- Birthmark Removal
- Scar Revision
- Tattoo Removal
- Mole Removal

VEIN TREATMENT

- Spider Veins
- Varicose Veins
- Facial Veins / Redness
- Sclerotherapy
- Laser Treatment
- Vein Microsurgery
- Cool-Touch Endo Venous Laser Therapy

Other: _____

PLEASE COMPLETE SIDE 2 OF THIS FORM.

PATIENT REGISTRATION FORM
CONTINUED

INSURANCE INFORMATION

Primary Insurance Company: _____
Member ID # / Policy No.: _____ Plan#/ Code: _____
Policy Holder's Full Name: _____ Relation to Patient: _____
Policy Holder's Date of Birth: _____ Social Sec. No. _____ - _____ - _____
Policy Holder's Employer: _____
Insurance Company Referral No.: _____

Secondary Insurance Company: _____
Member ID # / Policy No.: _____ Plan#/ Code: _____
Policy Holder's Full Name: _____ Relation to Patient: _____
Policy Holder's Date of Birth: _____ Social Sec. No. _____ - _____ - _____

I hereby assign all medical and surgical benefits to include major medical benefits to which I am entitled, including Medicare or any other health plan to Dr. Daniel A. Buscaglia. I authorize Dr. Buscaglia to submit claims to my insurance carrier or to its intermediaries for all services rendered on my behalf. I further authorize Dr. Buscaglia to release any information necessary to process my claim(s) to my insurance carrier or its intermediary. This assignment and authorization will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by the said insurance company. Any applicable collection fees will be added to the unpaid balance that necessitates the use of a collection agency.

Cancellation Policy: I understand that I should notify the office as soon as possible if I am unable to make my scheduled appointment. ONE WEEK NOTICE of cancellation is necessary for treatments requiring greater than a 30 minute visit, including but not limited to: Endovenous Laser Therapy, Ambulatory Phlebectomy, CO₂ Fraxel RE:PAIR, Laser Resurfacing and Thermage. I understand that failure to notify the office within this time period will result in a \$100.00 cancellation fee. If an appointment is cancelled with less than 24 hours notice, I understand that Dr. Buscaglia reserves the right to bill me \$50.00 for the lost appointment time.

Patient Signature: _____ Date: _____