The Vitiligo and Pigmentation Institute of Southern California

5670 Wilshire Blvd. Suite 650 ▪ Los Angeles, CA 90036 ▪ **Phone** (323) 467-4389 ▪ **FAX** (323)467-4488

PATIENT REGISTRATION FORM

Date: ____/____/____

PATIENT INFORMATION

Legal Name : _____
Last First Middle Initial

Date of Birth : ____/____/____ **Age:** _____ **Sex:** M F **SS# :** _____ - _____ - _____

Marital Status : ☐ **Single** ☐ **Partnered** ☐**Married** ☐ **Divorced** ☐ **Widowed**

Spouse Name : _____

Work Phone : _____ **Cell Phone :** _____

Drivers License #: _____ **State:** _____ **Exp. Date :** _____

Home Address : _____

_____
City State Zip Code

Home Phone : _____ **Cell Phone :** _____ **Email:** _____

EMPLOYMENT INFORMATION

Occupation : _____

Employer : _____

Address : _____
City **State** **Zip Code**

Work Phone : _____ **Ext.** _____

EMERGENCY CONTACT

Name: _____ **Phone Number (home) :** _____

Relationship : _____ **Phone Number (work) :** _____

INSURANCE INFORMATION: Do you have Health Insurance? ☐ **YES** ☐ **NO** (If yes, please complete below)

Primary Insurance : _____ **Secondary Insurance :** _____

Subscriber Name : _____ **Subscriber Name :** _____

Subscriber Birth Date : _____ **Subscriber Birth Date :** _____

Subscriber SS# _____ - ____ - _____ **Subscriber SS#** _____ - ____ - _____

Office Visit Co-pay : _____

**** Your co-pay is due the day of your appointment****

REFERRED BY: ☐ Current Patient ☐ Doctor ☐ Friend ☐ Internet ☐ Radio ☐ Other_____

Name of Referring Doctor: _____ Phone : _____

Address: _____City: _____ State: _____Zip _____