TIFFANI KIM INSTITUTE
MEDICAL • WELLNESS • SPA

# Patient Registration

Please Print

Patient Name: _____
First Last Middle Initial

Address: _____

City: _____ State: _____ ZIP: _____

Phone: _____ Alt. Phone: _____

DOB: _____ ☐ Male ☐ Female Email: _____

SSN: _____ Occupation: _____

Employer: _____ Phone: _____

Primary Insurance Co.: _____

I.D. # _____ Group #: _____

Name of Card Holder: _____

SSN# of Card Holder: _____

Relationship to Patient: _____

Secondary Insurance Co.: _____

Person to Contact in Case of Emergency _____ Relationship _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Work Phone _____

**PRIMARY CARE PHYSICIAN &/OR PHYSICIAN PROVIDING THIS REFERRAL**

Name Of Physician _____ Phone _____

Address _____ City _____ State _____ Zip _____

| **PAYMENT POLICY** | **INSURANCE POLICY** |
|---|---|
| All balances are due at the time of service. We accept Visa, MasterCard, Discover and American Express or cash. We do not accept checks or money orders. | Health insurance is a contract between you, the insured, and your insurance company. The Tiffani Kim Institute does not file or accept insurance payment for services other than dermatology. |

☐ I AUTHRIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS MY CLAIM, AND PAYMENT OF MEDICAL BENEFITS TO DR. NEAL A. SPERO. I UNDERSTAND I AM RESPONSIBLE FOR THE CHARGES NOT COVERED BY MY INSURANCE.

SIGNATURE _____ DATE_____