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 that the time of service. We accept Visa, MasterCard, Discover, and American Express, as well as check, money order or cash. There will be a $20 fee for any check that is returned by the bank	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_____