

**PATIENT REGISTRATION (please print)**

Patient  
Last Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Age \_\_\_\_\_  
First Name \_\_\_\_\_ MI \_\_\_\_\_ Social Security # \_\_\_\_\_  
Street Address \_\_\_\_\_ City \_\_\_\_\_  
State \_\_\_\_\_ Zip \_\_\_\_\_ Next of Kin \_\_\_\_\_  
Phone (H) \_\_\_\_\_ (W) \_\_\_\_\_ Alternate: \_\_\_\_\_ Marital  
Status \_\_\_\_\_  
Employer Name \_\_\_\_\_ Employer Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Email \_\_\_\_\_

**How did you hear about us:** \_\_\_\_\_

**If you are NOT a self-pay patient, please complete the remainder of the form**

If Patient Is Under The Age of 18, We Require Responsible Party DOB & SSN

Primary Insurance \_\_\_\_\_ Insurance Co. \_\_\_\_\_

Insurance ID# \_\_\_\_\_ Group # \_\_\_\_\_

Street Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Name Of Person Who Carries Insurance \_\_\_\_\_ SSN \_\_\_\_\_ DOB \_\_\_\_\_

Patient Relationship To Insured \_\_\_\_\_

Insured Employer \_\_\_\_\_ City/State/Zip \_\_\_\_\_

Workers' Compensation: Were You Injured On The Job? \_\_\_\_\_ Date of Injury \_\_\_\_\_

Workers' Compensation Carrier \_\_\_\_\_

Address \_\_\_\_\_ City/State/Zip \_\_\_\_\_

Were You Injured In An Auto Accident? \_\_\_\_\_ Accident Date \_\_\_\_\_

**ALL PROFESSIONAL SERVICES ARE CHARGED TO THE PATIENT. THE PATIENT IS RESPONSIBLE FOR ALL FEES REGARDLESS OF INSURANCE COVERAGE. I UNDERSTAND THAT I AM RESPONSIBLE FOR MY BILL. I HEREBY ASSIGN ALL MEDICAL AND SURGICAL BENEFITS TO INCLUDE MAJOR MEDICAL BENEFITS INCLUDING MEDICARE PRIVATE INSURANCE AND OTHER PLANS TO NAYAK PLASTIC SURGERY, P.C. I GIVE AUTHORIZATION TO RELEASE ANY INFORMATION TO MY INSURANCE COMPANY THAT IT MAY NEED.**

**DISCLOSURE: DR. L. MIKE NAYAK OF NAYAK PLASTIC SUGERY, PC, HAS A FINANCIAL INTEREST IN FRONTENAC SURGERY AND SPINE CARE CENTER, LLC.**

Patient's Signature (If 18 years or older) \_\_\_\_\_ Date \_\_\_\_\_

Parent/Guardian's Signature (If under 18 years) \_\_\_\_\_ Date \_\_\_\_\_