COOLEY
HAIR CENTER

Cooley Hair Center Patient Registration

PATIENT INFORMATION (Please Print) Today's Date ___/___/___

Name_____
Last First MI

Mailing Address_____
Street City State Zip

SS#_____ Date of Birth___/___/_____ Age_____ Sex_____

Home Phone (_____)_____ Work Phone (_____)_____ Marital Status_____

Employer_____ Address_____
(If Minor or if in College, Name of School)

INSURANCE INFORMATION (Please present insurance card at time of check in)

Primary Insurance Name_____
Name of Insured_____
Insured SS#_____
Insured DOB_____
Insured's ID#_____
Group #_____
Employer Name_____
Employer Address_____
_____
Employer Phone (_____)_____
Patient Relationship to Insured_____

Secondary Insurance Name_____
Name of Insured_____
Insured SS#_____
Insured DOB_____
Insured's ID#_____
Group #_____
Employer Name_____
Employer Address_____
_____
Employer Phone (_____)_____
Patient Relationship to Insured_____

Parent or Responsible Party (if different from pt.) **Name**_____

Address_____
Street City State Zip

Other Family members that are patients_____

Referred by:_____

Pharmacy of Choice_____ Phone (_____)_____

Primary Care Physician_____ Phone (_____)_____

In case of emergency notify_____ Phone (_____)_____

I authorize the release of medical information to my primary care/referring physician, to consultants If needed and as necessary to process insurance claims, insurance applications, and prescriptions. I also authorize payment of medical benefits to Cooley Hair Center and/or the physician.

Patient or Responsible Party Signature_____ Date_____/_____/_____

Payment is required for all services at the time they are rendered unless you are in an insurance plan with which we participate. For those patients applicable copayments will be collected when services are rendered or there will be a $10.00 charge to offset mailing expenses. We accept payment in the form at cash, check, Visa, Or MasterCard. In the event your account must be turned over to collections, a $25.00 collection fee will be added to your account. For appointments which are missed or cancelled with less than 24 hour notification there will be a $25.00 missed appointment fee added to your account. Your signature below signifies your understanding and willingness to comply with this policy.

Patient or Responsible Party Signature_____ Date_____/_____/_____

☐ **Copy of Insurance Card (both sides) attached.**

☐ **Power of Attorney on file.**