



Nicole Schrader, M.D., F.A.C.S.
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PATIENT REGISTRATION FORM (**PLEASE PRINT**) all items **MUST** be filled out

Patient Name: _____ Male _____ Female _____

Home Address: _____

City: _____ State: _____ Zip: _____ Home Telephone: _____

Patient's SS# _____ Patient's Birthday: _____

Cell: _____ **EMAIL ADDRESS:** _____

Referred by: _____ Referring Physician: _____

Responsible party for patient: _____ Relationship: _____

Emergency Contact: _____ Telephone: _____

Primary Insurance: _____ Address: _____

Subscribe/Policyholder: _____ Subscriber SS# _____

Date of Birth: _____ Relationship to Patient: _____

Home address: _____ Employer: _____

Telephone: _____ Cell: _____

*****Please give all insurance cards to receptionist***** Patient agrees & acknowledges that he/ she is responsible for all attorney fees and costs incurred by Facial Plastic & Reconstructive Surgery, LLC. Should any type of legal action be required to collect any unpaid balances by patient and / or the retention of an attorney by Facial Plastic & Reconstructive Surgery, LLC be required.

I authorize Nicole Schrader, MD to furnish information to my insurance carrier(s) concerning my illness (s) and treatment. I hereby assign all insurance payments to Nicole Schrader, MD C/O Facial Plastic & Reconstructive Surgery, LLC and agree to accept full responsibility for all charges for medical services provided to myself and/or any dependents that may not be covered by insurance. **WITHOUT EXCEPTION**, any charges for any medical services that are not covered by insurance are the full responsibility of the patient, or the responsible party who has signed for this patient.

SIGNATURE: _____ **Date:** _____

(If patient is a minor, relationship of person signed) _____