California Institute of Cosmetic & Reconstructive Surgery
VIPUL R. DEV, M.D./ NARAYANAN M. NAIR, M.D.
REGISTRATION FORM

Insurance patients: Please fill out the entire first page of this registration form (2nd page is for patients seeking Cosmetic treatment). Cosmetic patients: Please indicate "Cash Pay." Insurance information is preferred but optional. Please complete 2nd page of this form.

Date: **Primary Care Physician:**

PATIENT INFORMATION

Patient's Last Name: **First:** **Middle:**	☐ Mr. ☐ Miss ☐ Mrs. ☐ Ms.	**Marital status:** Single ☐ Mar ☐ Div ☐ Sep ☐ Wid ☐			
Is this your legal name? ☐ Yes ☐ No	**If not, what is your legal name?**	**Ethnicity:**	**Birth date:**	**Age:**	**Sex:** ☐ M ☐ F
Mailing address:	**City:**	**State:**	**ZIP Code:**		
Cell Phone no.: ( )	**Home Phone no.:** ( )		**Social Security No.:**		
Occupation:	**Employer:**	**Employer phone No.:** ( )			
Chose CICRS because/referred to clinic by (Please check one box): ☐ Dr. ☐ Insurance plan ☐ Hospital ☐ Family ☐ Friend ☐ Close to home/work ☐ Yellow Pages ☐ Other					
Email Address:	**Language Preference:**				

INSURANCE INFORMATION

(Please give your insurance card and co-payment to the receptionist.)

Person responsible for bill:	**Birth date:**	**Address (if different):**	**Home phone no.:** ( )
Is this person a patient here? ☐ Yes ☐ No			
Occupation:	**Employer:**	**Employer address:**	**Employer phone no.:** ( )
Is this patient covered by insurance? ☐ Yes ☐ No			
Please indicate primary insurance ☐ PPO ☐ HMO ☐ MEDICARE ☐ CASH PAY ☐ OTHER			

Subscriber's name:	**Subscriber's S.S. No.:**	**Birth date:**	**Group no.:**	**Policy no.:**	**Co-payment:** $
Patient's relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other					
Name of secondary insurance (if applicable):	**Subscriber's name:**		**Group no.:**	**Policy no.:**	
Patient's relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other					

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	**Relationship to patient:**	**Home phone no.:** ( )	**Work phone no.:** ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize [Name of Practice] or insurance company to release any information required to process my claims.

Patient/Guardian signature: **Date:**