Peter Helton, D.O.
2011 Westcliff Dr. Suite #9, Newport Beach, CA 92660
(949) 646-3376

PATIENT REGISTRATION FORM

(PLEASE PRINT CLEARLY AND FILL OUT COMPLETELY)

Patient's Name:________________________________ SSN:___________________

Street:_______________________________ Date of Birth:__________ Age______

City:_________________State/Zip________________HomePhone:_________________

Billing Address if different than above

Street:_______________________________

City:_________________State/Zip________________HomePhone:_________________

Marital Status: M S D W Referred By:_____________________________

Sex: M F Emergency Contact:_________________ Phone Number:____________

Responsible Party:______________________________ SSN:___________________

Street:_______________________________ Date of Birth:__________ Age______

City:_________________State/Zip________________HomePhone:_________________

Employer:____________________________ Work Phone:______________________

Past Medical History:____

Drug Allergies:____

Current Medications:____

Can confidential messages be left on your answering machine or voicemail? Y N

Please list, if any, person(s) whom we may inform about your general medical condition, your diagnosis, and/or your payment operations:

Name:__________________________________ Phone Number:_____________________

Name:__________________________________ Phone Number:_____________________

PRIMARY INSURANCE	SECONDARY INSURANCE
Name:____________________________	Name:________________________________
Address:_________________________	Address:_____________________________
C/S/Z:___________________________	C/S/Z:_______________________________
Phone:___________________________	Phone:_______________________________
ID#______________________________	ID#:_________________________________
Group#___________________________	Group#:______________________________
Insured Name:____________________	Insured Name:______________________
Insured DOB:_____________________	Insured DOB:_______________________

Assignment of Benefits:
I assign all insurance benefits to **Dr.Peter Helton**. I understand that I am financially responsible for all charges whether or not paid by my insurance. I understand that Dr. Helton's office is **not responsible to know my plan, what it will pay for or the deductible requirements**. I hereby authorize the doctor to release all information necessary to secure payment of benefits. I hereby give my consent for examination, treatment and insurance billing.

Permission for Photography:
I hereby give permission to *Helton Skin and Laser Institute* to take necessary clinical photographs of me with the understanding that such photographs are for confidential, clinical record purposes and that all photographs remain the property of the doctor.

Acknowledgment of Receipt of Notice of Privacy Practices:
I hereby acknowledge that I have received a copy of this medical practice's Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be posted in the reception area, and that I will be offered a copy of any amended Notice of Privacy Practices at each appointment.

Signature:____**Date:**_________________
Patient/Responsible Party

Print Name:____

If not signed by the patient, please indicate:

Relationship:____

Name of Patient:_______________________________________

Please give us your e-mail address if you would be interested in receiving our specials by e-mail: ____