



## Patient Registration Form (Rejuvenation Center)

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ M.I.: \_\_\_\_\_

Address: \_\_\_\_\_ Apt.#: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone Home: (\_\_\_\_) \_\_\_\_\_ Work: (\_\_\_\_) \_\_\_\_\_ Cell: (\_\_\_\_) \_\_\_\_\_

Which phone number would you like us to call for appointment confirmation? (\_\_\_\_) \_\_\_\_\_

E-mail address: \_\_\_\_\_ Driver's License#: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Occupation: \_\_\_\_\_ Sex: [ ] M [ ] F

Referred by: \_\_\_\_\_ Advertisement: \_\_\_\_\_

Reason for consultation: \_\_\_\_\_

Please read each paragraph and initial that you have read and understand the information.

\_\_\_\_\_ I understand that I will be charged \$30.00 for any insufficient check written to Hall Rejuvenation Center, LLC.

\_\_\_\_\_ I understand that Hall Rejuvenation Center, LLC has a 24 hour appointment cancellation policy. I understand that I will be charged \$40.00 for any missed or cancelled appointment if less than a 24 hour notice is given.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date

\_\_\_\_\_  
Physician

\_\_\_\_\_  
Date