DESERT HILLS
PLASTIC SURGERY CENTER

10001 South Eastern Avenue, Suite 406
Henderson, Nevada 89052

Patient Registration Form

(Please Print All Information)

Date: _____ Age: _____ Sex: _____

Name _____ Date of Birth _____

Social Security Number (last four numbers) _____ Marital Status _____

Address _____ Apt # _____

City _____ State _____ Zip _____

Phone # _____ Email address _____

How did you hear about our office? □Doctor _____ □Internet _____ □Other _____

Employer _____

Address _____ Phone # _____

City _____ State _____ Zip _____

Spouse/Parent Name _____ Phone #_____

Emergency Contact _____ Phone # _____
(Nearest relative not living with you, or personal contact)

Relationship to patient _____

Primary Insurance _____ Phone #_____

Policy Holder's Name _____ Birth Date _____ /_____/_____

Group # _____ ID # _____

**WE WILL NEED A PICTURE I.D.
AND A COPY OF YOUR INSURANCE
CARD.**