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.