

*Genetic institute of Anti-Aging*  
*Patient Registration Form*

What procedure(s) are you interested in? \_\_\_\_\_

Have you had a previous consultation? \_\_\_\_\_ Dr. \_\_\_\_\_

Social Security #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_  
(Last) (First) (M.I.)

Address: \_\_\_\_\_  
(Street) (City) (State) (Zip)

Drivers License #: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

E-Mail Address: \_\_\_\_\_

Home Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Mobile Phone: (\_\_\_\_) \_\_\_\_\_

Work Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

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Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Employer's Address: \_\_\_\_\_  
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Spouse: \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_ Phone \_\_\_\_\_  
\*\*\*\*\*

Person to Notify In Case Of Emergency: \_\_\_\_\_

Phone Number: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_  
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Responsible Person For Payment SS#: \_\_\_\_\_ Date Of Birth: \_\_\_\_\_

Name: \_\_\_\_\_ Driver's License #: \_\_\_\_\_

Address: \_\_\_\_\_  
(Street) (City) (State) (Zip)

Phone Number: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_  
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How were you referred to our office?  
\_\_Friend \_\_Relative \_\_Physician \_\_Internet \_\_Radio \_\_Television  
\_\_Print Ad \_\_Other: \_\_\_\_\_  
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I hereby authorize payment of any and all insurance benefits to be paid directly to Dr. \_\_\_\_\_ I understand that I am financially responsible for any charges regardless of insurance benefits and I am also responsible for any collection, legal or any other cost incurred should they be necessary on my account because of non-payment. I am aware that there will be a \$25 fee for any returned payments. I hereby authorize release of any medical and or other information for the process of insurance benefits for any medical/surgical services rendered.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Genetic Institute of Anti-Aging (GIAA)**

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