THE CLINIC OF PLASTIC SURGERY, PA

PATIENT REGISTRATION FORM

PATIENT INFORMATION

Patient _____ Home Phone _____

Mailing Address _____ Work Phone _____

City/State _____ Zip _____ Sex: M or F

Employer _____ Date of Birth _____

Social Security # _____ Marital Status: M W S D

Referred by _____

If injury, date of accident _____ Work Related? Y N

Contact person (other than Patient) for appointments changes/other information:

Name _____ Phone _____

RESPONSIBLE PARTY

Responsible Party _____ Home Phone _____

Social Security # _____ Work Phone _____

Mailing Address _____ Date of Birth _____

City/State _____ Sex: M or F

Employer _____ Marital Status: M W S D

INSURANCE INFORMATION

Insurance Co. _____

Address _____

_____

City/State _____ ZIP _____

Home phone _____

Insured's Name _____

Date of Birth _____ Sex: M F

Employer _____

Social Security # _____

Policy/IS # _____

Group # _____

Insurance Co. _____

Address _____

_____

City/State _____ ZIP _____

Home phone _____

Insured's Name _____

Date of Birth _____ Sex: M F

Employer _____

Social Security # _____

Policy/ID # _____

Group # _____

I authorize the physicians of The Clinic of Plastic Surgery to provide treatment and use my health information including photos for treatment, payment, and healthcare operations (TPO). This includes submitting information to my insurance company for the purpose of processing claims. I further authorize non-practice labs and radiology centers and pathologists ad radiologists who may interpret and/or report on diagnostic test ordered by the Clinic to provide such treatment and use under 18, parent/guardian requesting treatment assumes responsibility. Full payment is due at the time of service unless services are covered by an accepted insurance or third party coverage plan. In understand that if my account should ever require action by a collection agency or attorney in order to collect the balance owed, fees charged by these agents may be added to the balance due on my account.

I hereby acknowledge and agree to accept the policies stated above.

_____ _____ _____

Signature of Patient and /or parent, if patient under 18 Date