

**THE CLINIC OF PLASTIC SURGERY, PA**  
**PATIENT REGISTRATION FORM**  
————— **PATIENT INFORMATION** —————

Patient \_\_\_\_\_  
Mailing Address \_\_\_\_\_  
City/State \_\_\_\_\_  
Employer \_\_\_\_\_  
Social Security # \_\_\_\_\_  
Referred by \_\_\_\_\_  
If injury, date of accident \_\_\_\_\_

Home Phone \_\_\_\_\_  
Work Phone \_\_\_\_\_  
Zip \_\_\_\_\_ Sex: M or F  
Date of Birth \_\_\_\_\_  
Marital Status: M W S D  
Work Related? Y N

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

Name \_\_\_\_\_

Phone \_\_\_\_\_

**RESPONSIBLE PARTY**

Responsible Party \_\_\_\_\_  
Social Security # \_\_\_\_\_  
Mailing Address \_\_\_\_\_  
City/State \_\_\_\_\_  
Employer \_\_\_\_\_

Home Phone \_\_\_\_\_  
Work Phone \_\_\_\_\_  
Date of Birth \_\_\_\_\_  
Sex: M or F  
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 and 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. I 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