# PATIENT REGISTRATION

TODAY'S DATE _____

**PLEASE PRINT CLEARLY AND USE YOUR LEGAL NAME**

## IDENTIFICATION INFORMATION

PATIENT NAME | LAST | FIRST | MIDDLE INITIAL

☐ Male ☐ Female ☐ Single ☐ Married

IF UNDER 18 YEARS OF AGE, NAME OF PARENT OR GUARDIAN | IF MARRIED, SPOUSE'S NAME

HOME ADDRESS (INCLUDE P.O. BOX) | CITY | STATE | ZIP CODE

HOME TELEPHONE NO. ( ) | CELL PHONE NO. ( ) | PATIENT AGE | PT. DATE OF BIRTH | SOCIAL SECURITY NO.

PATIENT'S EMPLOYER (PARENT'S EMPLOYER IF MINOR) | ADDRESS | POSITION | # OF YEARS | WORK TELEPHONE NO. ( )

SPOUSE'S EMPLOYER | ADDRESS | POSITION | # OF YEARS | WORK TELEPHONE NO. ( )

REFERRED BY | INJURY DATE OR ONSET DATE | WAS THIS AN INJURY AT WORK? ☐ YES ☐ NO

PREVIOUS OR FAMILY PHYSICIAN | ADDRESS | TELEPHONE NO. ( )

REASON FOR VISIT | EMAIL

NAME OF PERSON **OUTSIDE YOUR HOUSEHOLD** IN CASE OF EMERGENCY

NAME | ADDRESS | TELEPHONE ( )

**CONSENT TO DISCUSS MEDICAL CARE:**

I AUTHORIZE PLASTIC & RECONSTRUCTIVE SURGEONS, INC. TO DISCUSS MY MEDICAL INFORMATION WITH THE FOLLOWING INDIVIDUALS I HAVE LISTED BELOW.

NAME | RELATIONSHIP

NAME | RELATIONSHIP

## COMPLETE BELOW FOR ALL INSURANCE TYPES

1. NAME OF INSURANCE CO. (PRIMARY) | ADDRESS OF INSURANCE CO.

SUBSCRIBER NAME | GROUP # / CLAIM # IF ON JOB | SUBSCRIBER SS # / ID # | EFFECTIVE DATE | SUBSCRIBER DATE OF BIRTH

2. NAME OF INSURANCE CO. (SECONDARY) | ADDRESS OF INSURANCE CO.

SUBSCRIBER NAME | GROUP # / CLAIM # IF ON JOB | SUBSCRIBER SS # / ID # | EFFECTIVE DATE | SUBSCRIBER DATE OF BIRTH

**RELEASE OF BENEFITS AND INFORMATION:**

I UNDERSTAND IT IS MY RESPONSIBILITY TO MEET THE REQUIREMENTS OF MY INSURANCE PLAN TO ENSURE BENEFITS ARE AVAILABLE FOR SERVICES RENDERED. SOME PLANS MAY REQUIRE ME TO NOTIFY THEM WITHIN 24-HOURS OF TREATMENT IF EMERGENT.

I AUTHORIZE MY INSURANCE BENEFITS TO BE PAID DIRECTLY TO PLASTIC & RECONSTRUCTIVE SURGEONS, INC. I AM FINANCIALLY RESPONSIBLE FOR ANY BALANCE DUE AND NON-COVERED SERVICES. I AUTHORIZE THE DOCTOR OR INSURANCE COMPANY TO RELEASE ANY INFORMATION REQUIRED FOR THIS CLAIM. MEDICAL INFORMATION MAY BE RELEASED TO YOUR PRIMARY REFERRING PHYSICIAN.

I HEREBY VOLUNTARILY GRANT PERMISSION TO PLASTIC & RECONSTRUCTIVE SURGEONS INC., P.S. AND THEIR DESIGNATED REPRESENTATIVES OR EMPLOYEES TO TAKE ANY PREOPERATIVE, INTRAOPERATIVE, AND POSTOPERATIVE PHOTOGRAPHS OF MYSELF FOR PURPOSES OF RECORD, EDUCATION, TO ASSIST THE DOCTOR IN THE PERFORMANCE OF MY SURGERY. I AUTHORIZE SUBMISSION OF MY PHOTOGRAPHS TO INSURANCE CARRIERS FOR THEIR USE IN PREDETERMINING COVERING FOR MY SURGERY. I HEREBY GRANT PERMISSION FOR THE USE OF ANY OF MY PHOTOGRAPHS IN THE CLINIC'S WEBSITE.

I ACKNOWLEDGE I HAVE RECEIVED A COPY OF THIS OFFICE'S NOTICE OF PRIVACY PRACTICES.

SIGNED _____

**AUTHORIZATION FOR THE TREATMENT OF A MINOR:**

I AUTHORIZE PLASTIC & RECONSTRUCTIVE SURGEONS, INC. TO TREAT THE MINOR PATIENT NAMED ABOVE.

SIGNED _____ RELATIONSHIP _____