Registration Form

❒ New Patient ❒ Update Date ____________________

Chart Number _________________ Dr. ________________________

Name of Patient ____
Last *First* *Middle*

Date of Birth ____________________ Age ________ Social Security Number _______________________

Home Address ____
Number *Street*

____
City *State* *Zip Code*

Home Telephone # __________________ Cell # ___________________ Business # ___________________

Patient Employed By _______________________________ Occupation ________________________________

Name of Spouse/Parent/Guardian ____________________________ Daytime Phone # __________________

Name of Insurance Carrier ____

Policyholder Name ____________________________ Date of Birth __________ Insured ID # ___________

Policyholder Employed By _________________________ Business Phone _____________________________

Name of Secondary Insurance Carrier ____

Policyholder Name ________________ Date of Birth _____________ Insured ID # ___________________

Has patient ever been seen by one of our physicians? ❒ Yes ❒ No
If yes, which one? ❒ Lowe ❒ Strawberry ❒ Buhrer ❒ Laughlin ❒ Spittler

Who is your Primary Care Physician (PCP)? __________________ Office Phone _______________________

Reason for today's visit __________________ Referred By ____________ Phone #____________________

Is this visit due to an injury? ❒ Yes ❒ No Injury Date___________________________________
Was this a work related injury? ❒ Yes ❒ No

Party Responsible for Payment of Account ____

I hereby authorize payment directly to Plastic Surgery Specialists, P.C. for the surgical and/or medical benefits, if any, otherwise payable to me under the terms of my insurance.

In the event it becomes necessary to forward your account for collection action due to nonpayment, the undersigned hereby agrees to pay 1% interest, per month, on all past due balances, attorney's fees of 33.3%, all court costs, and any additional charges for obtaining and verifying credit information during the collection of this account.

____
Date *Patient/Insured Signature* *Witness*

____
Update Signature *Date* *Update Signature* *Date*

PLEASE PRESENT YOUR HEALTH INSURANCE CARD AND DRIVERS LICENSE TO THE RECEPTIONIST