PLASTIC SURGERY SPECIALISTS, P.C.

Registration Form

□ New Patient □ Update Date _____

Chart Number _____ Email_____ Dr. _____

Name of Patient _____
Last First Middle

Date of Birth _____ Age _____ SS # _____ Ethnicity/Race_____

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? □ Buhrer □ Spittler

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

Reason for today's visit _____ Referred by _____

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's Signature Witness

_____ _____ _____ _____
Update Signature Date Update Signature Date

PLEASE PRESENT YOUR HEALTH INSURANCE CARD AND DRIVER'S LICENSE TO THE RECEPTIONIST