THE PLASTIC SURGERY GROUP, P.C.

PATIENT REGISTRATION

DATE:____________________

PATIENT NAME:____SEX(M)______(F)____ M/S/D:______________

STREET ADDRESS:____

TOWN:____STATE:___________________ZIP CODE_________________

HOME PHONE#:_____________________________________BUSINESS PHONE #___________________________________

PATIENT'S AGE:________________________DATE OF BIRTH__________________PATIENT SS#____________________

WHO REFERRED YOU TO OUR OFFICE:____

ADDRESS:____

FAMILY DOCTOR/PEDIATRICIAN:____PHONE #:_____________________

ADDRESS: ____

IN CASE OF EMERGENCY PLEASE NOTIFY:____

RELATIONSHIP TO PATIENT:_______________________________________PHONE #:_____________________

PATIENT'S OR GUARDIAN'S EMPLOYER:____

ADDRESS:____PHONE #:_____________________

REASON FOR VISIT:____DATE OF ONSET/ACCIDENT: ______________

ACCIDENT DESCRIPTION:____

HOW / WHERE INJURY OCCURRED: ____

WAS PATIENT INJURED ON THE JOB ? (YES)_____(NO)____ IN AN AUTO ACCIDENT?(YES)________(NO)_____

(IF ON THE JOB INJURY OR NO FAULT, PLEASE COMPLETE INFORMATION ON REVERESE SIDE)

FINANCIAL RESPONSIBILITY

INSURANCE # 1

NAME OF INSURANCE CARRIER:____

ADDRESS:____

NAME OF POLICY HOLDER:____________________________________NAME OF EMPLOYER PROVIDING COVERAGE:______________________

POLICY HOLDER'S SS#__________________________ POLICY HOLDER'S DATE OF BIRTH:_________________SEX: (M)____________(F)___________

POLICY ID # :____GROUP#:__________________PLAN#:________________

INSURANCE # 2

NAME OF INSURANCE CARRIER:____

ADDRESS:____

NAME OF POLICY HOLDER:____________________________________NAME OF EMPLOYER PROVIDING COVERAGE:______________________

POLICY HOLDER'S SS#__________________________ POLICY HOLDER'S DATE OF BIRTH:_________________SEX: (M)____________(F)___________

POLICY ID # :____GROUP#:__________________PLAN#:________________

IF YOUR INSURANCE REQUIRES A REFERRAL, IT IS YOUR RESPONSIBILITY TO FURNISH US WITH IT PRIOR TO SEEING THE DOCTOR. FAILURE TO DO SO WILL RESULT IN THE PATIENT BEING RESPONSIBLE FOR THE BILL.

THE PLASTIC SURGERY GROUP, P.C.

SELF-PAY: (Must be completed if you have no insurance)

RESPONSIBLE PARTY'S NAME:_______________ SS#:_______________

STREET ADDRESS:_______________

TOWN: _______________ STATE:_______________ ZIP CODE:_______________

EMPLOYER NAME: _______________ ADDRESS:_______________

I.D. RECEIVED: (to be completed by receptionist) _______________

FOR ON THE JOB INJURY:

DATE OF ACCIDENT: _______________ TIME: _______________ AM PM TOWN WHERE ACCIDENT TOOK PLACE_______________

DESCRIPTION OF ACCIDENT: _______________

EMPLOYER:_______________ SUPERVISOR:_______________

INSURANCE COMPANY: _______________ ADDRESS:_______________

PHONE #: _______________ CONTACT: _______________

POLICY #:_______________ CARRIER CASE #:_______________ WCB CASE #:_______________

ARE YOU STILL WORKING? (YES)_______________ (NO)_______________ LAST DATE WORKED:_______________

FOR AUTOMOBILE ACCIDENT: (Please supply receptionist with copy of insurance ID card)

DATE OF ACCIDENT:_______________ PATIENT WAS: DRIVER:_____ PASSENGER:_____ PEDESTRIAN:_____ WORKING AUTO_____

NAME OF POLICY HOLDER: _______________ PHONE #:_______________

INSURANCE COMPANY:_______________ ADDRESS:_______________
PHONE #:_______________ CONTACT:_______________
POLICY #:_______________ FILE #: _______________

INSURANCE PAYMENT ORDER & AUTHORIZATION TO RELEASE INFORMATION:
I HEREBY AUTHORIZE MY INSURANCE COMPANY(S) KNOWN BY THE NAME(S) OF _______________
TO PAY DIRECTLY TO THE PLASTIC SURGERY GROUP, P.C., BENEFITS DUE ME OUT OF INDEMNITY UNDER THE TERMS OF MY POLICY. PAYMENT IS AUTHORIZED UPON YOUR RECEIPT OF THEIR ITEMIZED BILL. THIS POLICY WAS IN FULL FORCE AND EFFECT AT THE TIME SERVICES WAS RENDERED. IN THE EVENT THAT WE HAVE TO REFER YOUR ACCOUNT FOR LEGAL ACTIONS, ANY AND ALL REASONABLE COLLECTION AND/ OR ATTORNEY FEES WILL BE ADDED TO THE PATIENT'S BILL.

I HEREBY AUTHORIZE THE PLASTIC SURGERY GROUP, P.C. TO FURNISH INFORMATION TO INSURANCE CARRIER AND/ OR EMPLOYERS CONCERNING ILLNESS AND TREATMENT RECEIVED BY ME FOR THE PURPOSE OF RESOLVING MY CLAIM(S) FOR MEDICAL SERVICE:

INSURED NAME :_______________

LEGAL SIGNATURE: _______________ DATE:_______________