PLASTIC SURGERY CENTER OF THE SOUTH

WELCOME TO OUR OFFICE

PATIENT REGISTRATION FORM

PATIENT INFORMATION

Acct#_____

HOW WERE YOU REFERRED TO OUR PRACTICE?

REASON FOR TODAY'S VISIT?

NAME: TITLE FIRST M.I. LAST

ADDRESS APT# CITY STATE ZIP

HOME PHONE ( ) WORK PHONE ( ) CELL PHONE ( ) S.S.#

❑ CONSENT TO ADD MY NAME TO YOUR EMAIL LIST EMAIL ADDRESS:

BIRTHDATE: | AGE: | SEX: (circle) M F | MARITAL STATUS (circle one) Single Married Widowed Divorced

EMPLOYER NAME & ADDRESS WORK PHONE ( )

SPOUSE'S NAME WORK ADDRESS
SPOUSE'S EMPLOYMENT WORK PHONE ( )

PARENT'S NAME ADDRESS
IF MINOR PHONE ( )

LOCAL RELATIVE OR FRIEND
NAME PHONE ( )

ADDRESS CITY STATE ZIP

RESPONSIBLE PARTY (if other than patient)

NAME/FIRST M.I. LAST BIRTHDATE:

ADDRESS
(IF NOT THE SAME) CITY STATE ZIP

HOME PHONE ( ) WORK PHONE ( ) S.S.#

EMPLOYER NAME ADDRESS CITY STATE ZIP

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY

ADDRESS CITY STATE ZIP

INSURED'S NAME ID# GROUP# DOB:

SECONDARY INSURANCE COMPANY

ADDRESS CITY STATE ZIP

INSURED'S NAME ID# GROUP# DOB:

REFERRING SOURCE

Consent for Treatment/Payment Policies/Assignment of Benefit/Insurance Release:

I hereby acknowledge that it is the policy of this office that all payments are to be made at the time of each office visit. I acknowledge that I am responsible for the payment of all services rendered by this office to my dependent or myself. Any account over 60 days from date of service will accrue an interest charge of 1 1/2 % per month, which is equal to 18% per year. I authorize the release of any medical information necessary to process insurance claims. I hereby assign payment directly to Plastic Surgery Center of the South, for basic benefit as well as major medical benefits herein specified and otherwise payable to me, but not to exceed the regular charges for the period of treatment. In accordance with the suggestions adopted by the American Board of Plastic Surgery, Inc., it is routine that the fee for elective procedures be paid prior to surgery. I hereby voluntarily consent to treatment at this office and authorize such treatments, examinations, medications, anesthesia, surgical operations and diagnostic procedures as ordered by the attending physician.

Signature of Patient _____ Date _____