

PATIENT INFORMATION RECORD

Plastic & Reconstructive Surgery Associates, Inc. welcomes you as a patient.
Our physicians and healthcare staff are here to serve you.

DATE	REFERRED BY/ADDRESS IF KNOWN	ACCOUNT NUMBER
		L H
FAMILY PHYSICIAN/ADDRESS IF KNOWN		

PATIENT AND FAMILY INFORMATION

LAST NAME	FIRST	MIDDLE	AGE	SOCIAL SECURITY NUMBER	DATE OF BIRTH	SEX
SPOUSE'S LAST NAME	FIRST	MIDDLE	AGE	SOCIAL SECURITY NUMBER	DATE OF BIRTH	SEX
ADDRESS: NUMBER AND STREET		CITY	STATE	ZIP		
EMAIL	HOME PHONE	WORK PHONE	CELL PHONE			
MARITAL STATUS	EMPLOYER NAME AND ADDRESS					
M S D W						

RESPONSIBLE PARTY *(Please complete if patient is a minor or covered by spouse)*

IF OTHER RESPONSIBLE PARTY, SUCH AS SPOUSE OR PARENT OR OTHER RELATIONSHIP, PLEASE INDICATE NAME, RELATIONSHIP AND ALTERNATIVE BILLING ADDRESS:

NAME: LAST	FIRST	MIDDLE	AGE	SOCIAL SECURITY NUMBER	DATE OF BIRTH
ADDRESS: NUMBER AND STREET		CITY	STATE	ZIP	PHONE

INSURANCE INFORMATION *(Please present your insurance card(s) to Registration)*

PRIMARY INSURANCE COMPANY NAME AND ADDRESS:		SECONDARY INSURANCE COMPANY NAME AND ADDRESS:	
EMPLOYEE/SUBSCRIBER NAME:	DATE OF BIRTH	EMPLOYEE/SUBSCRIBER NAME:	DATE OF BIRTH
I.D. OR CERTIFICATE NUMBER		I.D. OR CERTIFICATE NUMBER	
GROUP OR POLICY NUMBER:	EFFECTIVE DATE	GROUP OR POLICY NUMBER:	EFFECTIVE DATE

IF VISIT IS RELATED TO INJURY:

PERSONAL INJURY? AUTO ACCIDENT? WORK RELATED? OTHER _____ **DATE OF INJURY:** _____

INSURANCE NAME AND ADDRESS	EMPLOYER/RESPONSIBLE PARTY	CLAIM NUMBER
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EMERGENCY NOTIFICATION *(Other than above):*

IN CASE OF EMERGENCY, PLEASE CONTACT: _____ ADDRESS _____

NAME:		
RELATIONSHIP	DAYTIME PHONE	EVENING PHONE

FINANCIAL INFORMATION

If we are contracted with your insurance carrier we will bill them directly. You will be required to pay your portion of the charges and/or copayment on the day the services are rendered. If we are not contracted with your insurance carrier, you will be required to pay the total charges on the day the services are rendered. As a courtesy to you, we will submit the initial insurance bill to your carrier.

INSURANCE RELEASE: I hereby authorize Plastic & Reconstructive Surgery Associates, Inc. to furnish my Insurance Company with all information which they may require concerning my illness/injury for reimbursement for services rendered.

ASSIGNMENT OF BENEFITS: I hereby assign to Plastic and Reconstructive Surgery Associates, Inc. my benefits for my medical and surgical services. A photocopy of the authorization is as valid as the original.

I HEREBY GUARANTEE PAYMENT IN FULL OF ANY AND ALL CHARGES IN CONSIDERATION FOR MEDICAL SERVICES RENDERED, OR TO BE RENDERED.

X

Responsible Party Signature

Date