

Plastic Surgical Associates REGISTRATION FORM

(Please Print)

Today's Date:				PCP:			
PATIENT INFORMATION							
Patient's last name:		First:	Middle:	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs.	<input type="checkbox"/> Miss <input type="checkbox"/> Ms.	Marital status: Single <input type="checkbox"/> Mar <input type="checkbox"/> Div <input type="checkbox"/> Sep <input type="checkbox"/> Wid <input type="checkbox"/>	
Is this your legal name? <input type="checkbox"/> Yes <input type="checkbox"/> No	If not, what is your legal name?		(Former name):		Birth date:	Age:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F
Street address:			Social Security no.:		Home phone no.: ()		
P.O. box:		City:		State:		ZIP Code:	
Occupation:		Employer:			Employer phone no.: ()		
Referred By: (please check one box):				<input type="checkbox"/> Dr.		<input type="checkbox"/> Insurance plan	<input type="checkbox"/> Hospital
<input type="checkbox"/> Family	<input type="checkbox"/> Friend	<input type="checkbox"/> Close to home/work	<input type="checkbox"/> Yellow Pages	<input type="checkbox"/> Other			
Other family members seen here:		Email Address:		May we contact you by email?			

INSURANCE INFORMATION							
(Please give your insurance card to the receptionist.)							
Person responsible for bill:		Birth date:	Address (if different):			Home phone no.: ()	
Is this person a patient here? <input type="checkbox"/> Yes <input type="checkbox"/> No							
Occupation:	Employer:	Employer address:				Employer phone no.: ()	
Is this patient covered by insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No							
Please indicate primary insurance		<input type="checkbox"/> BC/BS	<input type="checkbox"/> Tufts	<input type="checkbox"/> Harvard/Pilgrim	<input type="checkbox"/> self pay	<input type="checkbox"/> Medicare	
<input type="checkbox"/> Medicaid	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Other			
Subscriber's name:		Subscriber's S.S. no.:	Birth date:	Group no.:		Policy no.:	Co-payment: \$
Patient's relationship to subscriber:		<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child	<input type="checkbox"/> Other		
Name of secondary insurance (if applicable):		Subscriber's name:			Group no.:	Policy no.:	
Patient's relationship to subscriber:		<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child	<input type="checkbox"/> Other		

IN CASE OF EMERGENCY			
Name of local friend or relative (not living at same address):		Relationship to patient:	Home phone no.: ()
			Work phone no.: ()
<p>The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize [Name of Practice] or insurance company to release any information required to process my claims.</p>			
<hr/> <i>Patient/Guardian signature</i>		<hr/> <i>Date</i>	