

Southern Plastic Surgery, P.C. Patient Registration

Today's Date: _____

Welcome to our office. We are committed to providing the best, most comprehensive care possible. We encourage you to ask questions. Please assist us by providing the following information. All information is confidential and is released only with your consent.

Patient Name _____		Date of Birth _____	Age _____	Sex _____
Social Security Number _____		Driver's License Number _____		
Home Address _____		City/State _____	Zip _____	
Mailing Address (If Different) _____				
Home Telephone () _____		Work Telephone () _____		
Occupation _____		Employer's Name _____		
Employer's Address _____		City/State _____	Zip _____	
E-Mail Address _____		Cell Phone/Pager No. _____		
Spouse's Name _____		Address _____		
Employer Name and Address _____				
Home Telephone () _____		Work Telephone () _____		
Parent if Patient is a Minor _____		Date of Birth _____	Age _____	
Social Security Number _____		Driver's License Number _____		
Home Address _____		City/State _____	Zip _____	
Mailing Address (If Different) _____				
Home Telephone () _____		Work Telephone () _____		
Occupation _____		Employer's Name _____		
Employer's Address _____		City/State _____	Zip _____	
Does the child live with both parents? Yes No				
Notify in Case of Emergency _____		Relationship _____		
Home Telephone () _____		Work Telephone () _____		
Nearest Relative (Not living with you) _____		Relationship _____		
Home Telephone () _____		Work Telephone () _____		
Whom May We Thank for Referring You to Our Practice? _____				
Financial Information (Person responsible for fees)				
Name _____		Relationship _____	DOB _____	
Address _____		City/State _____	Zip _____	
Primary Insurance				
Insurance Company _____		Subscriber Name _____		
Subscriber's Social Security No. _____		Relationship to Patient _____		
Secondary Insurance				
Insurance Company _____		Subscriber Name _____		
Subscriber's Social Security No. _____		Relationship to Patient _____		
Were you injured on the job? Yes No		Have you informed your employer? Yes No		

Southern Plastic Surgery, P.C.
BRIEF HISTORY

In an effort to serve you better, we request that you provide us with the following information. We need this information to give you the best care and treatment possible. All information is held strictly confidential and is released only with your written consent.

Last Name:	First:	Age:	Sex:	Doctor Notes <i>please do not write in this area</i>
Presenting Problem or Proposed Surgery:				
ILLNESS/INJURY: Please check if you have ever had:				
<input type="checkbox"/>	High blood pressure	<input type="checkbox"/>	Hepatitis	
<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	Yellow jaundice	
<input type="checkbox"/>	Peptic ulcers	<input type="checkbox"/>	Abdominal bleeding	
<input type="checkbox"/>	Heart attack	<input type="checkbox"/>	Lung problems/asthma	
<input type="checkbox"/>	Chest pain/tightness	<input type="checkbox"/>	Shortness of breath	
<input type="checkbox"/>	History of heart murmur	<input type="checkbox"/>	Psychiatric care	
<input type="checkbox"/>	Stroke	<input type="checkbox"/>	Any other hospital	
<input type="checkbox"/>	Cancer	<input type="checkbox"/>	admissions or medical	
<input type="checkbox"/>	Accidents/broken bones (list)	<input type="checkbox"/>	conditions?	
<input type="checkbox"/>		<input type="checkbox"/>		
<input type="checkbox"/>		<input type="checkbox"/>		
OPERATIONS: List the names and dates of all operations you have had.				
Year	Name of Operation	Type of Anesthetic, If Known	Complications	
Have you ever had a blood transfusion? <input type="checkbox"/> Yes <input type="checkbox"/> No Date: _____				
FEMALES ONLY: Are you pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No				
DRUGS: Please list all drugs you take and their dosages.				
Drug	Dosage	Drug	Dosage	
ALLERGIES: Please list type and reaction <input type="checkbox"/> NONE				
Name of Drug	Reaction	Name of Drug	Reaction	
Do you smoke? What? _____ How much? _____				
Quit when? _____				
Do you use a nicotine substitute? <input type="checkbox"/> Yes <input type="checkbox"/> No Which one? _____				
Do you drink alcohol? <input type="checkbox"/> Yes <input type="checkbox"/> No Amount? _____				
The above information is true and accurate.				
Patient Signature (parent if patient is a minor) _____				

SOUTHERN PLASTIC SURGERY,P.C.

**RECEIPT OF NOTICE OF PRIVACY PRACTICES
WRITTEN ACKNOWLEDGEMENT FORM.**

I, _____, have reviewed a copy of Southern Plastic Surgery's Notice of
Patient Name
Privacy Practices.

Signature of Patient

Date

Patient: _____

BASIC POLICY: Payment for service is due in full at the time service is provided in our office.

For Patients with Insurance: We bill most insurance carriers for you if proper paperwork is provided to us. We will also bill most secondary insurance companies for you. Co-Payments and deductibles are due at the time of service. Since your agreement with your insurance carrier is a private one, we do not routinely research why an insurance carrier has not paid or why it paid less than anticipated for care. If an insurance carrier has not paid within 60 days of billing, professional fees are due and payable in full from you.

Medicare Patients: We will bill Medicare for you. We will also bill secondary insurance for you. All co-payments or deductibles are due and payable at the time service is provided.

Medicaid Patients: All medicaid patients must provide a current, valid certificate before being seen.

Surgery Fees: All copays, deductibles, and payments for non-covered surgical procedures are due prior to surgery. Prior authorization may be required by your carrier.

Non-Covered Services: Any care not paid for by your existing insurance coverage will require payment in full at the time services are provided or upon notice of insurance claim denial.

Cosmetic Services: All cosmetic services are to be paid in full 10 days before the surgery date.

Auto Injury Cases: This office does bill auto insurance for auto accident cases. We do Not accept liens.

Worker's Compensation: If your injury is work-related, we will need the case number and carrier name prior to your visit in order to bill the worker's compensation insurance company.

Medicare Patients: Signature on File I, _____, request payment of authorized Medicare benefits be made on my behalf to Southern Plastic Surgery, P.C. for any services furnished me by the provider. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits payable to related services.

I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in Item 9 of the HCFA-1500 form or elsewhere on other approved claim forms or electronically submitted claims, my signature authorized releasing of the information to the insurer or agency shown. In Medicare assigned cases, the provider or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible for the deductible, coinsurance, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

Signature _____ Date: _____

Assignment of Insurance Benefits Patients with insurance please read and sign below.

I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, private and/or auto insurance, and any other health plans, to Southern Plastic Surgery, P.C. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure the payment.

Signature _____ Date: _____

I have read, understood, and agreed to the above financial policy for payment of professional fees.
The patient is ultimately responsible for all professional fees.

Signature _____ Date: _____