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
please do not write in this area

Presenting Problem or Proposed Surgery:

ILLNESS/INJURY: Please check if you have ever had:

	High blood pressure		Hepatitis
	Diabetes		Yellow jaundice
	Peptic ulcers		Abdominal bleeding
	Heart attack		Lung problems/asthma
	Chest pain/tightness		Shortness of breath
	History of heart murmur		Psychiatric care
	Stroke		Any other hospital
	Cancer		admissions or medical
	Accidents/broken bones (list)		conditions?

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? ❑ Yes ❑ No Date: _____

FEMALES ONLY: Are you pregnant? ❑ Yes ❑ No

DRUGS: Please list all drugs you take and their dosages.

Drug	Dosage	Drug	Dosage

ALLERGIES: Please list type and reaction ❑ NONE

Name of Drug	Reaction	Name of Drug	Reaction

Do you smoke? What? _____ How much? _____
Quit when? _____
Do you use a nicotine substitute? ❑ Yes ❑ No Which one? _____
Do you drink alcohol? ❑ Yes ❑ No Amount? _____

The above information is true and accurate.
Patient Signature (parent if patient is a minor) _____

PROMINA Physician Advantage

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

Southern Plastic Surgery P.C.
Financial Policy

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:_____