Southern Plastic Surgery, P.C.
David M. Whiteman, M.D., F.R.C.S.(c)

Patient Registration

We welcome you 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.

Date: _____

Patient Name _____ Date of Birth _____ Age____ Sex _____

Social Security # _____ Driver's License # _____

Home Address _____

City,State _____,_____ Zip _____

Mailing Address (If Different) _____

Primary Telephone _____ Secondary Telephone _____

Email Address _____

Employer _____ Occupation _____

Employer's Address _____ Work Telephone _____

Parent Name(s) if patient is a minor_____

Does this child live with both parents? □ Yes □ No

Notify in Case of Emergency _____ Relationship _____

Telephone _____ Alternate Telephone _____

Nearest Relative (Not living with you) _____ Relationship _____

Telephone _____ Alternate 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 # _____ Relationship to Patient _____

Secondary Insurance

Insurance Company _____ Subscriber Name _____

Subscriber's Social Security # _____ Relationship to Patient _____

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Financial Policy

Patient _____

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

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.

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: _____

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Brief History

Date: _____

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:
Presenting Problem or Proposed Injury:			

Doctor Notes
Please do not write in this area

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/problems		Psychiatric care
	Stroke		Any other hospital admissions or medical conditions?
	Cancer		Sleep apnea
	Accidents/broken bones (list)		
	Blood clots/pulmonary embolism		
	Substantial weight loss		

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? □ Yes □ No 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) _____