Social Security Number: ______________________________

# CHART INFORMATION

Date of first visit: ___________________
Date Revised: ______________________
Account Number: ___________________

Age: ____________________________

Patient's Name: ______________________________________ (Last / First / Middle) Date of Birth: _________________

Residence Address: ______________________________________ (Number / Street / City / State / Zip Code)

Mailing Address: ______________________________________ (Number / Street / City / State / Zip Code)

Home Phone: (____) _____________________ Height: ________________ Weight: ________________ Sex: M F

Cell Phone: (____) _____________________ E-mail Address: ______________________________________

Occupation: _________________________________ Employer: ______________________________________

Work Phone: (____) _____________________ Business Address: ______________________________________

Name of spouse / Parent or Legal Guardian (if patient is a minor): ______________________________________

Work Phone: (___) _____________________ Occupation:______________________________________

Emergency contact other than spouse/phone: ______________________________________

Reason for this visit *(Write in your own words)*: ______________________________________
______________________________________________________________________________

Have you ever been treated elsewhere for this problem? _____________ By Whom? ______________________________

Have you or any of your family members been treated here before? ______________________________________

Who is your primary care physician? _________________________________ Address: ______________________________
Phone Number: ______________________________

Who were you referred by: __________________________________________ Address: ______________________________

Who is financially responsible for your bill? ______________________________________

**PRIMARY INSURANCE INFORMATION**

Insurance Company ______________________________________

Circle one: Group Policy or Individual Policy

If Group, Name of Employer ______________________________

Policy # ________________________ Group # ______________

Insured Person ___________________________ DOB _________

Insured Soc Sec # ______________________________________

**SECOND INSURANCE**

Insurance Company ______________________________________

Circle one: Group Policy or Individual Policy

If Group, Name of Employer ______________________________

Policy # ____________________ Group # _________________

Insured Person ____________________________ DOB _______

Insured Soc Sec # ______________________________________

**Is your insurance an HMO or PPO? _______________ Does your insurance require pre-admission certification? _____________________**
**Does your insurance require that you go to a specific hospital? ________________**
**IF ACCIDENT RELATED, PLEASE COMPLETE THE FOLLOWING:**

Date of Accident:_____________________ Time: ___________ Describe how accident occurred: ______________________________
**Are any legal proceedings involved with respect to your reason for this visit? ____________Yes _________ No**

ALL PROFESSIONAL SERVICES RENDERED ARE CHARGED TO THE PATIENT, NECESSARY FORMS WILL BE COMPLETED TO EXPEDITE INSURANCE CARRIER PAYMENTS. THE PATIENT IS RESPONSIBLE FOR ALL FEES, REGARDLESS OF INSURANCE COVERAGE. IT IS CUSTOMARY TO PAY FOR SERVICES WHEN RENDERED UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE IN ADVANCE.
I HEREBY ASSIGN TO THE PHYSICIAN(S) ALL PAYMENTS FOR MEDICAL SERVICES RENDERED TO MYSELF OR MY DEPENDENTS. I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY INSURANCE.
WITH MY CONSENT, THE CENTER FOR PLASTIC & RECONSTRUCTIVE SURGERY MAY USE AND DISCLOSE PROTECTED HEALTH INFORMATION (PHI) ABOUT ME TO CARRY OUT TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS (TPO); AND MAY MAIL, CALL, OR E-MAIL TO MY HOME OR OTHER DESIGNATED LOCATION ANY ITEMS THAT ASSIST IN CARRYING OUT TPO, SUCH AS APPOINTMENT REMINDERS & PATIENT STATEMENTS. I UNDERSTAND MY RECORDS MAY BE REVIEWED FOR QUALITY ASSURANCE.

DATE: ______________ SIGNATURE: ______________________________________
(MUST BE SIGNED BY PARENT OR LEGAL GUARDIAN IF APPLICABLE)