ATLANTA PLASTIC SURGERY, P.C.

Members AMERICAN SOCIETY OF PLASTIC SURGEONS

Date _____ Dr# _____

Account # _____ Doctor _____

How did you hear about Atlanta Plastic Surgery?

Referring Physician - Name _____ Other - Name _____

Address _____ Address _____

Physican's Phone (_____) _____ _____

Patient Information

Patient's Name _____ DOB ___/___/___ Age _____
Last First Middle

Mailing Address _____
Street/Apt.

_____
City State Zip

S.S.N. ___-___-___ Sex ❍ M ❍ F ❍ Single ❍ Married ❍ Widowed ❍ Divorced

Home Phone (_____) _____ Work Phone (_____) _____ E-mail _____

Employer's Name _____ Occupation _____

Employer's Address _____
Street City State Zip

Do you have (primary) insurance through your employer ❍ Yes ❍ No

If yes, please provide additional information requested on the reverse side of form.

Your reason for visiting the doctor today

_____

Spouse Information

Spouse's Name _____ DOB ___/___/___ Age _____
Last First Middle

Home Phone (_____) _____ Work Phone (_____) _____ S.S.N. ___-___-___

Employer's Name _____ Occupation _____

Employer's Address _____
Street City State Zip

Do you have (secondary) insurance through your spouse's employer ❍ Yes ❍ No

If yes, please provide additional information requested on the reverse side of form.

Parent or Guardian Information

(For patient who is a minor)

Is patient covered by insurance through father's employer ❍ Yes ❍ No

Is patient covered by insurance through mother's employer ❍ Yes ❍ No

If yes, please provide additional information requested on the reverse side of form.

Parent/Guardian's Name _____ DOB ___/___/___ Age _____
Last First Middle

Mailing Address _____
Street City State Zip

Father

Father's Name _____
Last First Middle

Employer _____

Employer's Address _____
Street

_____
City State Zip

Employer's Phone (_____) _____

DOB ___/___/___ S.S.N. ___-___-___

Mother

Mother's Name _____
Last First Middle

Employer _____

Employer's Address _____
Street

_____
City State Zip

Employer's Phone (_____) _____

DOB ___/___/___ S.S.N. ___-___-___

Emergency Information

Please identify the name of a person who does not live with the patient

Name _____ Phone (_____) _____ Relationship to Patient _____

Other Information

Have you been a patient in this office before this occasion? ❍ Yes ❍ No When _____

If yes, who was your doctor at that time? _____

Were you treated at a hospital at that time? ❍ Yes ❍ No

When _____ By whom _____

Please allow our receptionist to copy your insurance cards

1st Insurance to be filed:

❍ Group ❍ Individual ❍ Auto ❍ Medicare ❍ Medicaid ❍ Other

Insurance Co. Name _____

Insured's Name _____ S.S.N. _____-_____-_____

Policy # _____ Group Name/Number _____

Mailing Address for Claim _____
Street or P.O. Box City State Zip

2nd Insurance to be filed:

❍ Group ❍ Individual ❍ Auto ❍ Medicare ❍ Medicaid ❍ Other

Insurance Co. Name _____

Insured's Name _____ S.S.N. _____-_____-_____

Policy # _____ Group Name/Number _____

Mailing Address for Claim _____
Street or P.O. Box City State Zip

Worker's Compensation Claims

Contact Person _____ Date of Injury _____ Date You Reported Injury _____

Employer's Name _____ Phone (_____) _____

Address _____

Description of Accident _____

Office Use Only **Ver. by** **Date**

Due to the high cost of billing, we must request payment for all office visits at the time of service. If you wish to file your own insurance claim, we will provide sufficient information on your paid receipt for you to do so. Insurance is a contract between you and your carrier. We are happy to contact the insurance carrier to facilitate payment on your behalf. We welcome questions concerning fees.

I accept responsibility as Guarantor for the above-named patient. I authorize release of any medical information necessary to process claims for services rendered. I assign, transfer, and set over to Atlanta Plastic Surgery, P.C. all of my rights, title, and interest to my medical reimbursement benefits under my insurance policy. I authorize payment of these benefits to Atlanta Plastic Surgery, P.C. I accept responsibility for any balances unpaid by my insurance company.

_____

Signature (Patient or Authorized Person) Date