PATIENT REGISTRATION INFORMATION

please **PRINT** and complete **ALL** sections below

PATIENT PERSONAL INFORMATION			
		M F	/ /
last name	first name	Sex	date of birth
home address	city, state, zip	driver's license	Social Security Number
home phone number	cell phone number	email	
employer	employer address	occupation	
married partner single widowed			
marital status	spouse/partner name	spouse/partner phone number	

SUBSCRIBER/RESPONSIBLE PARTY INFORMATION			
suibscriber/responsible party name		date of birth	
spouse dependant parent			
relationship to patient	Social Security Number (tricare/military)	home phone	work phone
responsible party address	city, state, zip	employer	

PATIENT INSURANCE INFORMATION---please present insurance card to receptionist			
PRIMARY insurance company name		Member ID	Group #
SECONDARY company name		Member ID	Group #
Subscriber Name	Subscriber Date of Birth	Relationship to Patient	
Yes No			
IS YOUR INSURANCE AN HMO?	**PCP Name**	**PCP Phone#**	

REFERRAL/PHARMACY INFORMATION	
who referred you to our office?	what is the name of your preferred pharmacy? City and phone number

EMERGENCY CONTACT			
name of person not living with you	address	city, state, zip	relationship
home phone number	work/cell phone number		

ASSIGNMENT OF BENEFITS

I hereby give lifetime authorization for payment of insurance benefits to be made directly to Texas Plastic Surgery Associates, for all medical and surgical services rendered. I understand that I am financially responsible for all charges whether or not they are covered by insurance. In the event of default, I agree to pay all costs of collection, and reasonable attorney's fees. I hereby authorize this healthcare provider to release all information necessary to my insurance company to secure payment of benefits. I further agree that a copy of this agreement shall be as valid as the original.

PATIENT/REPRESENTATIVE SIGNATURE:		**Date:**