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River City Plastic Surgery, P.C.

confidential medical record

PATIENT REGISTRATION FORM

PLEASE COMPLETE ENTIRE FORM

PATIENT NAME: _____
Last Name First Name Middle Name Suffix (Jr, Sr)

MAILING ADDRESS: _____
Street or PO Box City State Zip

How Did You Hear About Us? (circle one) Friend/Relative Yellow Pages Print Ad Radio Internet Physician_____ Other _____

SSN #: _____-_____-_____	**SEX:** ☐M ☐F	RACE: ____	**BIRTH DATE :** _____ MM/DD/YYYY	**MAR STATUS:** ☐ Mar ☐ Single ☐ Div ☐ Widow

HM PH #: **WK #:** **CELL #:**

EMAIL ADDRESS:

PRIM CARE DR: _____ **REFERRING DR:** _____ **SPOUSE NAME**_____ **WK/CELL#**_____

IF RETIRED (CHECK BOX) ☐ **OR COMPLETE THE FOLLOWING:**

PATIENT'S EMPLOYER: _____ **JOB TITLE:** _____

Employer Address: _____
Street or PO Box City State Zip

Required:
EMERGENCY CONTACT (OTHER THAN SPOUSE): _____ **RELATIONSHIP:** _____

Contact Hm Ph #: _____ Wk Ph#: _____ Cell #: _____

*PLEASE PRESENT PAYMENT DUE UPON CHECK-IN.

FINANCIALLY RESPONSIBLE PARTY: *(IF OTHER THAN PATIENT, e.g. spouse, parent or guardian)*

Full Name: _____ Relationship: _____

Address: _____
Street or PO Box City State Zip

Home Ph #: _____ Work Ph #: _____

Social Security #: _____-_____-_____ Date of Birth: _____
MM/DD/YYYY

Employer Name/Address: _____

PLEASE PRESENT YOUR INSURANCE CARD(S) *(IF CARDS UNAVAILABLE, PLEASE **COMPLETE THE FOLLOWING**)*

Primary Insurance: _____ Policy #: _____ Group #: _____

Secondary Insurance: _____ Policy #: _____ Group #: _____

PLEASE READ THIS ENTIRE SECTION AND SIGN BELOW:

I, the undersigned, agree that I am responsible for all fees at the time of service unless other arrangements have been made in advance. I, the undersigned, agree that I am financially responsible for the co-payment, deductible, and co-insurance as applicable to my insurance coverage, and for any and all other charges not covered by my insurance upon receipt for request of such payment. I acknowledge that any returned checks and past due balances may be subject to collection fees and interest charges; and that I may be charged for "no show" appointments if not cancelled in advance.

I, the undersigned, request that payment of authorized benefits under my medical insurance carrier(s) be made to this provider for any services furnished to me by this provider. THIS IS A DIRECT ASSIGNMENT OF MY BENEFITS UNDER THIS POLICY. I authorize this provider to release to my insurance carrier, and/or agents of these companies, and/or the listed responsible party, any information needed to determine these benefits or the benefits payable for related services. I authorize this provider to initiate a complaint on my behalf to the Insurance Commissioner for any misconduct by my insurance carrier.

I, the undersigned, hereby authorize Dr. Barbara E. Howard and staff to administer such treatment and to perform such procedures as are considered therapeutically or diagnostically necessary. I grant permission for the use of any record, illustration, photograph or image created in my case, for use in examination, testing, credentialing and/or certifying purposes by the American Board of Plastic Surgery.

SIGNATURE (patient/guardian): **DATE:**