River City Plastic Surgery, P.C.

All information will be part of your 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_____

****LAST 4 DIGITS SSN: _____	SEX: ☐M ☐F	RACE: ____	BIRTH DATE : _____ MM/DD/YYYY	MAR STATUS: ☐ Mar ☐ Single ☐ Div ☐ Widow
HM PH #:	WK #:		CELL #:	

EMAIL ADDRESS: ☐ OK TO RECEIVE EMAIL / TEXT NOTICES

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

COMPLETE THE FOLLOWING: **RETIRED** ☐ **STAY-AT-HOME MOM/WIFE** ☐

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

Employer Address: _____
Street or PO Box City State Zip

Required:
EMERGENCY CONTACT (IF NOT SPOUSE): _____ **RELATIONSHIP:** _____

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

PLEASE PRESENT PHOTO ID AND PAYMENT DUE UPON CHECK-IN.

FINANCIALLY RESPONSIBLE PARTY (IF NOT PATIENT) SUCH AS PARENT/GUARDIAN/SPOUSE:

Full Name: _____ Relationship: _____

Address: _____
Street or PO Box City State Zip

Home Ph #: _____ Work/Cell Ph #: _____

Date of Birth: _____MM/DD/YYYY

Employer Name / Address: _____

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 agree to remit payment for office visit fees, procedure fees, and any and all other charges prior to treatment or upon request of such payment. I understand that this provider does not contract with health insurance, but rather offers private patient contracts with discounted self-pay rates. I acknowledge that any charges by this practice are separate from my health insurance, and that I will not attempt to seek reimbursement from my insurance once I have agreed to pay this physician directly on a self-pay basis. 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, hereby authorize Dr. Barbara E. Howard and staff to administer such treatment and to perform such procedures as considered therapeutically or diagnostically necessary. I grant permission for the use of my records for use in medical treatment, testing, credentialing, quality assurance, peer review and/or certifying purposes by those required to review such information including designated medical personnel, the Am Board of Plastic Surgery and the AAAASF Accreditation Board. (This is not the granting of permission to use patient photos for marketing purposes or releasing of private health information to outside parties other than those noted.)

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