PATIENT REGISTRATION

Patient's Name _____ **Employer** _____

Address _____ Address _____

City _____ State _____ Zip _____ City _____ State _____ Zip _____

Home phone (_____) _____ Employer phone (_____) _____

Cell phone (_____) _____ Best # to reach you at (_____) _____

Birthdate _____ Age _____ Sex _____ Emergency contact _____

Social security # _____ Relationship _____ Phone (_____) _____

Email Address _____

Responsible party (if not the patient) _____ Relationship _____

Address _____ Social security # _____

City _____ State _____ Zip _____ Employer _____

Home telephone (_____) _____ Address _____

Employer telephone # _____ City _____ State _____ Zip _____

INSURANCE INFORMATION: If we have a COPY OF YOUR CARD and the patient is the policy holder, skip this section.

PRIMARY COVERAGE

Insurance Company _____

Policy holder name _____

Policy ID# _____

Policy number or SS# _____

Policy holder birthdate _____

Group name or number _____

Insurance Address _____

City _____ State _____ Zip _____

Telephone _____

SECONDARY COVERAGE

Insurance Company _____

Policy holder name _____

Policy ID# _____

Policy number or SS# _____

Policy holder birthdate _____

Group name or number _____

Insurance Address _____

City _____ State _____ Zip _____

Telephone _____

WORKERS COMPENSATION CLAIMS

Date of injury _____ BWC Claim # _____

Managed Care Organization _____ Telephone _____

Address _____ City _____ State _____ Zip _____

I AUTHORIZE RELEASE OF INFORMATION TO ALL MY INSURANCE COMPANIES.
I AUTHORIZE PAYMENT DIRECTLY TO PLASTIC SURGERY INSTITUTE OF DAYTON, INC.
I UNDERSTAND THAT I AM ULTIMATELY RESPONSIBLE FOR MY BILL.
I UNDERSTAND THAT IF I EXPECT ANY PORTION OF MY BILL TO BE REIMBURSED OR PAID BY INSURANCE OR A PREPAID HEALTH PLAN, IT IS MY RESPONSIBILITY TO ENSURE THAT MY DOCTOR HAS MET MY CARRIER'S REQUIREMENTS.
I AUTHORIZE THE USE OF THIS INFORMATION ON ALL MY INSURANCE CLAIM SUBMISSIONS OBTAIN PAYMENT FROM MY INSURANCE COMPANY.
I AUTHORIZE MY DOCTOR TO ACT AS MY AGENT IN HELPING ME OBTAIN PRECERTIFICATION FROM MY INSURANCE COMPANY AND TO OBTAIN PAYMENT FROM MY INSURANCE COMPANY.
I AUTHORIZE MY DOCTOR TO PHOTOGRAPH ME WITH RESPECT TO MY MEDICAL CARE FOR MEDICAL EDUCATION, TEACHING PURPOSES, PRESENTATION TO LAY PERSONNEL, AND RELEASE TO MY INSURANCE COMPANY IF REQUESTED.

Signature _____ Date _____