PATIENT REGISTRATION SHEET

PATIENT INFORMATION:

LAST NAME:_____ FIRST:_____ MIDDLE INIT:_____ SEX: M F

ADDRESS:_____ CITY:_____ STATE:_____ ZIP:_____

DATE OF BIRTH:_____ SS#_____ MARITAL STATUS: M S D W SEP

CELL PH#:_____ WORK PH#:_____ HOME PH#:_____

EMAIL ADDRESS:_____ SPOUSE NAME:_____

EMPLOYER:_____

EMPLOYER ADDRESS:_____ CITY:_____ STATE:_____ ZIP:_____

WORK RELATED INJURY: Y N DATE OR ONSET OF INJURY:_____

IF PATIENT IS 18 OR UNDER:

FATHER'S FULL NAME:_____ CELL PH#:_____ WORK PH#_____

MOTHER'S FULL NAME:_____ CELL PH#:_____ WORK PH#:_____

RACE:_____ ETHNICITY (Choose one): _____LATINO/HISPANIC _____ NON LATINO/HISPANIC PREFERRED LANGUAGE:_____

WHO IS FINANCIALLY RESPONSIBLE FOR PAYMENT?

If patient is a minor, under age 18, both parents are responsible for payment of services rendered to their child (according to state law).

If patient is the responsible party, do not complete this section - CHECK HERE ❑

LAST NAME:_____ FIRST:_____ MIDDLE INIT:_____

ADDRESS:_____ CITY:_____ STATE:_____ ZIP:_____

CELL PH#:_____ WORK PH#:_____

EMPLOYER:_____ SS#:_____

INSURANCE INFORMATION: In addition to listing all insurance plans, please present your insurance cards so that we may obtain a copy.

PRIMARY INSURANCE:_____

CLAIMS MAILING ADDRESS:_____

CITY:_____ STATE:_____ ZIP:_____ PHONE#:_____

INSURED'S NAME:_____ DATE OF BIRTH:_____ RELATIONSHIP TO PT:_____ SEX: M F

INSURED'S ADDRESS:_____ INSURED'S SS#:_____

EMPLOYER:_____ GROUP#:_____ ID#:_____

SECONDARY INSURANCE:_____

CLAIMS MAILING ADDRESS:_____

CITY:_____ STATE:_____ ZIP:_____ PHONE#:_____

INSURED'S NAME:_____ DATE OF BIRTH:_____ RELATIONSHIP TO PT:_____ SEX: M F

INSURED'S ADDRESS:_____ INSURED'S SS#:_____

EMPLOYER:_____ GROUP#:_____ ID#:_____

NEAREST RELATIVE OR FRIEND, NOT LIVING WITH YOU, THAT WE MAY CONTACT IF WE ARE UNABLE TO REACH YOU OR IN CASE OF AN EMERGENCY:

NAME:_____ PHONE#:_____

PLEASE COMPLETE THE BACK OF THIS FORM

CONSENT AUTHORIZATIONS

Consent to Treatment and Other Authorizations

I hereby consent to medical treatment rendered by Dr. Edmond and/or Samer W. Cabbabe and also acknowledge my receipt of the physician's current Privacy Notice. In the course of my treatment I provide my consent for the physician to E-prescribe medication orders directly to my pharmacy through the Electronic Medical Record, as well as consenting to an invitation from the Patient Portal, the part of the medical record where I may sign up to view my records on-line.

If my treatment requires billing to my insurance carrier, I hereby authorize release of any medical information necessary to bill my insurer, including medical records to substantiate any dispute involving a credit card company for services previously rendered and paid. I also authorize payment of medical/surgical benefits paid by my insurer to be made directly to Plastic Surgery Consultants or Dr. Edmond and/or Samer Cabbabe.

SIGNATURE:_____ DATE:_____

Consent for E-MAIL Contact

SIGNATURE:_____ DATE:_____

Photography Release

I understand that pre-treatment and post-treatment photographs are necessary to follow my medical care. My pre-treatment and post-treatment photos may be viewed for educational purposes by my physician or patients; or to be sent to my insurance company for pre-approval of reconstructive procedures. Educational purposes may include: use in physician consults with individual patients, use in physician seminars presented to potential patients or medical associations and use in social media including the practice website for prospective patients.

Plastic Surgery Consultants/Advanced Plastic Surgery has my permission to use the photographs for these purposes. This consent will be in effect until physician discontinues use of these photographs. I understand that my photographs will be handled with the highest possible level of confidentiality.

SIGNATURE:_____ DATE:_____

PRINTED NAME:_____