ATLANTA PLASTIC SURGERY, P.C.

Members AMERICAN SOCIETY OF PLASTIC SURGEONS

Date ____________________ Dr# ____________________

Account # ________________ Doctor ________________

How did you hear about Atlanta Plastic Surgery?

Referring Physician - Name ____________________ Other - Name ____________________

Address ____________________ Address ____________________

Physican's Phone (_____) ____________________ ____________________

Patient Information

Patient's Name ____________________ DOB ____/____/____ Age ________
Last First Middle

Mailing Address ____________________
Street/Apt.

____
City State Zip

S.S.N. _____ - _____ - _____ Sex ❍ M ❍ F ❍ Single ❍ Married ❍ Widowed ❍ Divorced

Home Phone (_____) ____________ Work Phone (_____) ____________ E-mail ____________

Employer's Name ____________________ Occupation ____________________

Employer's Address ____________________
Street City State Zip

Do you have (primary) insurance through your employer ❍ Yes ❍ No

If yes, please provide additional information requested on the reverse side of form.

Your reason for visiting the doctor today

____

Spouse Information

Spouse's Name ____________________ DOB ____/____/____ Age ________
Last First Middle

Home Phone (_____) ____________ Work Phone (_____) ____________ S.S.N. _____ - _____ - _____

Employer's Name ____________________ Occupation ____________________

Employer's Address ____________________
Street City State Zip

Do you have (secondary) insurance through your spouse's employer ❍ Yes ❍ No

If yes, please provide additional information requested on the reverse side of form.

Parent or Guardian Information

(For patient who is a minor)

Is patient covered by insurance through father's employer ❍ Yes ❍ No
Is patient covered by insurance through mother's employer ❍ Yes ❍ No

If yes, please provide additional information requested on the reverse side of form.

Parent/Guardian's Name ____________________ DOB ____/____/____ Age ________
Last First Middle

Mailing Address ____________________
Street City State Zip

Father

Father's Name ____________________
Last First Middle

Employer ____________________

Employer's Address ____________________
Street

____
City State Zip

Employer's Phone (_____) ____________

DOB ____/____/____ S.S.N. _____ - _____ - _____

Mother

Mother's Name ____________________
Last First Middle

Employer ____________________

Employer's Address ____________________
Street

____
City State Zip

Employer's Phone (_____) ____________

DOB ____/____/____ S.S.N. _____ - _____ - _____

Emergency Information

Please identify the name of a person who does not live with the patient

Name ______________________ Phone (_____) ______________ Relationship to Patient ______________

Other Information

Have you been a patient in this office before this occasion? ❍ Yes ❍ No When ______________

If yes, who was your doctor at that time? ______________

Were you treated at a hospital at that time? ❍ Yes ❍ No

When ______________ By whom ______________

Please allow our receptionist to copy your insurance cards

1st Insurance to be filed:

❍ Group ❍ Individual ❍ Auto ❍ Medicare ❍ Medicaid ❍ Other

Insurance Co. Name ______________

Insured's Name ______________ S.S.N. _____-_____-_____

Policy # ______________ Group Name/Number ______________

Mailing Address for Claim ______________
Street or P.O. Box City State Zip

2nd Insurance to be filed:

❍ Group ❍ Individual ❍ Auto ❍ Medicare ❍ Medicaid ❍ Other

Insurance Co. Name ______________

Insured's Name ______________ S.S.N. _____-_____-_____

Policy # ______________ Group Name/Number ______________

Mailing Address for Claim ______________
Street or P.O. Box City State Zip

Worker's Compensation Claims

Contact Person ______________ Date of Injury ______________ Date You Reported Injury ______________

Employer's Name ______________ Phone (_____) ______________

Address ______________

Description of Accident ______________

Office Use Only **Ver. by** **Date**

Due to the high cost of billing, we must request payment for all office visits at the time of service. If you wish to file your own insurance claim, we will provide sufficient information on your paid receipt for you to do so. Insurance is a contract between you and your carrier. We are happy to contact the insurance carrier to facilitate payment on your behalf. We welcome questions concerning fees.

I accept responsibility as Guarantor for the above-named patient. I authorize release of any medical information necessary to process claims for services rendered. I assign, transfer, and set over to Atlanta Plastic Surgery, P.C. all of my rights, title, and interest to my medical reimbursement benefits under my insurance policy. I authorize payment of these benefits to Atlanta Plastic Surgery, P.C. I accept responsibility for any balances unpaid by my insurance company.

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Signature (Patient or Authorized Person) Date