Main Line Plastic Surgery PC
PATIENT REGISTRATION FORM

Patient's Name: _____ Sex: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Date of Birth: _____ Age: _____ Social Security Number: _____

Home Phone: _____ Cell Phone: _____ Email address: _____

Marital Status (circle): Minor Single Married Divorced Separated Widow(er)

If a minor, give parents and / or legal guardian's names: _____

Minor resides with: _____ **

**Note: Custodial Parent / Guardian receives all correspondence and billing information from this office.

Person to Contact in Case of Emergency _____ Relationship: _____ Phone: _____

Reason for Office Visit: _____

Family Doctor: _____ Phone: _____ Referred By: _____ Phone (if doctor): _____

Dermatologist: _____

Would you like us to send your chart notes to your doctor? **Yes** **No** If Yes, which one? _____

How did you hear about us? (circle one) Patient Newspaper Yellow Pages Internet Site: _____

Other: _____

FOR WORKERS COMP ONLY: Patient's Employer: _____ Work Phone: _____

Is this a work related injury? Yes No **Is this an auto related injury? Yes No**

HEALTH INSURANCE INFORMATION

****(MEDICAL & RECONSTRUCTIVE PATIENTS ONLY)**

Primary Health Insurance: _____

Identification Number: _____ Group Number: _____

Insured's Name: _____ Relationship to Patient: _____

Insured's Date of Birth: _____ Insured's Employer: _____

Secondary Health Insurance: _____

Identification Number: _____ Group Number: _____

Insured's Name: _____ Relationship to Patient: _____

Insured's Date of Birth: _____ Insured's Employer: _____

ASSIGNMENT AND RELEASE: I understand that I am financially responsible for all services. I hereby authorize release of any information concerning my (or my child's) health care, advice and treatment provided, for the purpose of evaluating and administrating claims for insurance benefits as well as that needed for treatment by other physicians. I also hereby authorize payment of insurance benefits directly to Main Line Plastic Surgery PC and/or Raymond Jean MD.
Insurance co-payments are due at the time of service. I understand that this account is my responsibility. Should the account be referred to an attorney or collection agency, the undersigned shall pay reasonable attorney fees and collection expense. All delinquent accounts bear interest at the legal rate.

Signed: _____ Date: _____

Signature of Patient or Parent / Guardian if Minor