CARE PLASTIC·SURGERY

PATIENT REGISTRATION FORM

Full Name: _____ Birthday & Age: _____ Today's Date: _____

SS # _____ Gender: _____ Marital Status: ◯ **M** ◯**S** ◯**D** ◯**W** ◯**Oth**

Ethnicity/Race: _____ Preferred Language: _____

Home Address: _____

Mailing Address: _____

Phone Home: _____ Work: _____ Cell: _____

Email Address: _____

Your email address is not shared. However, **please refer to our Notice of Privacy Practices regarding communication via email**.

I do NOT want to receive appt reminders on my phone? ☐ **Who is your cell carrier?** _____

EMPLOYMENT INFORMATION

☐ Employed ☐ Retired ☐ Full-Time Student ☐ Part-Time Student ☐ Unemployed

Occupation: _____

Employer: _____

Work Address: _____

REFERRAL & EMERGENCY CONTACT INFORMATION

How did you hear of us? Please choose all that apply.

☐ Friend - _____
☐ www.CAREplasticsurgery.com
☐ Carolina Woman
☐ Durham Magazine
☐ Google Search Term _____
☐ Online Review Source _____
☐ Facebook
☐ Patient - _____

Referring provider or physician's name and address: _____ Phone: _____

Emergency Contact: _____ Phone: _____

Relationship: _____

Pharmacy: _____ Phone: _____

COMMUNICATION

Your privacy is important to us. **Please check all that apply.** I wish to be contacted in the following ways….

Mobile/Cell Phone:
- ☐ DO NOT CALL or leave message
- ☐ Leave call-back number only

Work Phone:
- ☐ DO NOT call or leave message
- ☐ Leave call-back number only

Home Phone:
- ☐ Do NOT CALL or leave message
- ☐ Leave call-back number only

Written Communication:
- ☐ Do NOT mail my home address
- ☐ Do NOT mail to my work/office

RELEASE OF MEDICAL INFORMATION

I authorize CARE Plastic Surgery, P.A. to release any information acquired during the course of my examination and treatment for the purposes of continuing my medical care or for billing/collecting matters.

Signature: _____ Date: _____

MEDICARE PATIENTS ONLY

I request that payment of authorized Medicare benefits be made either to me or on my behalf to CARE Plastic Surgery, P.A. for any services furnished me by that physician or supplier. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

Signature: _____ Date: _____

AUTHORIZATION OF PAYMENT

I authorize payments of medical benefits for services rendered by CARE Plastic Surgery, to be made to CARE Plastic Surgery, P.A. I understand that I am ultimately fully responsible for payment of services rendered. Your signature authorizes us to send a claim to your insurance company if applicable.

Signature: _____ Date: _____

PHOTO CONSENT

I grant permission to Dr. Brian S. Coan for the use of the photograph(s) for medical, internal office use, internet marketing and publication. I understand that I may revoke this authorization at any time by notifying CARE Plastic Surgery in writing. Images will be stored in a secure location and only authorized staff will have access to them.

Signature: _____ Date: _____

HIPAA PRIVACY PRACTICES

I have been offered and/or received the office's Notice of Privacy Practices.

Signature: _____ Date: _____