

RENAISSANCE

PLASTIC SURGERY, P.C.

PATIENT REGISTRATION

PATIENT INFORMATION

NAME: _____ DATE: _____

SOCIAL SECURITY: _____ AGE: _____

DATE OF BIRTH: _____ MARITAL STATUS _____ RACE _____ SEX _____

HOME ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: _____ WORK: _____ CELL: _____

CAN WE CONTACT YOU AND OR LEAVE A MESSAGE AT THESE NUMBERS? YES NO

EMAIL ADDRESS: _____

CAN WE SEND CONFIDENTIAL INFORMATION TO YOU? YES NO

PATIENT EMPLOYER: _____ OCCUPATION: _____

ADDRESS: _____ STATE: _____ ZIP: _____

INSURANCE INFORMATION

1ST INSURANCE CO: _____ INSURED NAME: _____

INSURED DATE OF BIRTH: _____ SOCIAL SECURITY: _____ PHONE: _____

ADDRESS: _____ STATE: _____ ZIP: _____

2ND INSURANCE CO: _____ INSURED NAME: _____

INSURED DATE OF BIRTH: _____ SOCIAL SECURITY: _____ PHONE: _____

ADDRESS: _____ STATE: _____ ZIP: _____

RESPONSIBLE PARTY

RESPONSIBLE PARTY: _____ RELATIONSHIP: _____

EMERGENCY CONTACT: _____ PHONE: _____

HOW DID YOU HEAR ABOUT OUR OFFICE? Radio _____ Newspaper _____ Magazine _____ Yellow Pages _____ Internet _____
Physician _____ Friend _____ Family _____

I hereby authorize payment directly to Renaissance Plastic Surgery, PC and/or Renaissance Surgical Centre', LLC for any surgical and/or medical benefits due. I further authorize release of any information, photographs, and or slides acquired in the course of my examination and/or treatment to recover such payments. I understand that payment is due at the time of service. I further understand and agree that my insurance is filed as a courtesy and that I am ultimately responsible for any balance due after the insurance company has made payment.

PATIENT SIGNATURE

4030 Riverside Park Boulevard

• Macon, GA 31210

DATE

478-474-2200

• Fax 478-314-0740