

PATIENT REGISTRATION



Ohio Plastic and Reconstructive Surgery LLC

112 Morey Dr. Marysville, OH 43040

Acct # \_\_\_\_\_
New Patient

Please Fill Out Completely and Print Clearly

Today's Date \_\_\_\_\_ Appointment Date \_\_\_\_\_

Patient Name \_\_\_\_\_

Birthdate \_\_\_\_\_ Age \_\_\_\_\_ Sex: Female \_\_\_\_\_ Male \_\_\_\_\_

Social Security Number \_\_\_\_\_ Primary Language: \_\_\_\_\_

Ethnicity: Hispanic or Latino \* Non-Hispanic or Latino (circle one)

Race: (circle one)

American Indian/Native Alaskan \* Asian \* African/African American \* Caucasian \* Native Hawaiian/Pacific Islander

Patient Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Mobile Phone \_\_\_\_\_ Email \_\_\_\_\_

Preferred pharmacy name and telephone number \_\_\_\_\_

Is it okay to leave messages containing medical information on voicemail? If yes, indicate authorized phone numbers:

\_\_ Home \_\_ Cell \_\_ Work \_\_ Other \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Marital Status \_\_\_\_\_ Spouse Name \_\_\_\_\_

Do you have an Advance Directive? \_\_\_\_\_. If yes, please provide our office with a copy for your medical record.

In the event you are unable to make decisions for yourself, who do you authorize to make decisions on your behalf?

Name/Relationship \_\_\_\_\_ Phone Number \_\_\_\_\_

If Patient Is a Minor

Responsible Party \_\_\_\_\_

Mother's Name \_\_\_\_\_
Address (if different from above) \_\_\_\_\_

Father's Name \_\_\_\_\_
Address (if different from above) \_\_\_\_\_

Home Phone \_\_\_\_\_

Home Phone \_\_\_\_\_

Work Phone \_\_\_\_\_

Work Phone \_\_\_\_\_

Mobile Phone \_\_\_\_\_

Mobile Phone \_\_\_\_\_

SSN \_\_\_\_\_

SSN \_\_\_\_\_

DOB \_\_\_\_\_

DOB \_\_\_\_\_

Reason for Visit \_\_\_\_\_

How Did You Hear About Us? \_\_\_\_\_

Primary Care Physician

Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ St \_\_\_\_\_ Zip \_\_\_\_\_

Phone \_\_\_\_\_

Specialty \_\_\_\_\_

Referring Physician

Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ St \_\_\_\_\_ Zip \_\_\_\_\_

Phone \_\_\_\_\_

Specialty \_\_\_\_\_

Other Physicians/Doctors

Specialty

Phone

Table with 3 columns: Other Physicians/Doctors, Specialty, Phone. Multiple rows for listing additional doctors.

PATIENT INSURANCE INFORMATION



Ohio Plastic and Reconstructive Surgery LLC

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Please Fill Out Completely and Print Clearly

Patient Name \_\_\_\_\_ Date of birth \_\_\_\_\_ Date \_\_\_\_\_

Primary Insurance

Insurance Co. Name \_\_\_\_\_
Insurance Co. Address \_\_\_\_\_
Policy Holder's Name \_\_\_\_\_
Relationship to Patient \_\_\_self \_\_\_spouse \_\_\_child \_\_\_other \_\_\_\_\_
Employer \_\_\_\_\_
Policy # \_\_\_\_\_
Group # \_\_\_\_\_
Policy Holder's SSN \_\_\_\_\_
Policy Holder's Birth date \_\_\_\_\_

I confirm the above patient named has no other insurance coverage

Signature of Patient/Responsible Party \_\_\_\_\_ Date \_\_\_\_\_

Secondary Insurance

Insurance Co. Name \_\_\_\_\_
Insurance Co. Address \_\_\_\_\_
Policy Holder's Name \_\_\_\_\_
Relationship to Patient \_\_\_self \_\_\_spouse \_\_\_child \_\_\_other \_\_\_\_\_
Employer \_\_\_\_\_
Policy # \_\_\_\_\_
Group # \_\_\_\_\_
Policy Holder's SSN \_\_\_\_\_
Policy Holder's Birth date \_\_\_\_\_

\*\*ALL PATIENTS OR RESPONSIBLE PARTIES MUST SIGN BELOW REGARDLESS OF INSURANCE STATUS OR SELF PAY SITUATIONS

I hereby authorize pre and post-operative photographs to be taken of me for medical records and insurance claim purposes.
I authorize I do not authorize the use of my photographs for educational purposes.
I agree that this office may release medical records pertaining to my treatment to my insurance company or other third parties responsible for payment of my medical charges, including review activities related to my physician's participation with my health plan.
Disclosure of ownership: none.

I hereby assign all major medical and/or surgical insurance benefits to which I am entitled, including private insurance, Medicare and any other health plan or insurance benefits, to the provider indicated above. I understand that I am financially responsible for all charges whether or not paid by said insurance, unless assignee has executed an agreement with my insurance provider or plan. I understand that if such an agreement has been executed, I am responsible to pay any deductible and/or co-payment required under the terms of my insurance plan. Should collection procedures become necessary, I agree to pay the collection agency's cost and/or reasonable attorney's fees.

A photocopy of this assignment/authorization is to be considered as valid as the original.

Signature of Patient or Responsible Party \_\_\_\_\_ Date \_\_\_\_\_