Plastic Surgery Associates

24 Memorial Medical Drive • Greenville, SC 29605 • (864) 295-4160

REGISTRATION FORM

(Please Print) **Account #**

PATIENT INFORMATION

Patient's Last Name:	First:	Middle:	SS #	Birth Date: / /	Age:

Marital Status:	Sex:	Ethnicity:	Race:		Preferred Language:
☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widow	☐ Female ☐ Male	☐ Non-Hispanic ☐ Declines ☐ Unreported	☐ Caucasian ☐ American Indian ☐ Native Hawaiian ☐ Other Pacific Island	☐ African American ☐ Alaska Native ☐ Asian ☐ Unreported ☐ Declines	_____

Home Phone No:	Cell No:	Email Address:	Contact Preference: ☐ Phone ☐ Phone & Email ☐ Email

Mailing Address:	City:	State:	Zip Code:

Occupation:	Employer:	Employer Address:

What is the reason for your visit today?	Who may we thank for referring you to our practice?	Address:	Email:

GUARANTOR: INFORMATION

(Please give your insurance card and photo ID (Driver's License) to the receptionist.)

Person Responsible for Bill:	Birth Date: / /	Address (if different):	Home Phone No.: ( )

Occupation:	Employer:	Employer's Address:	Employer's Phone No.: ( )

Is this patient covered by insurance? ❒ Yes ❒ No Is this related to: ❒ MVA ❒ WC ❒ Liability

Name of Insurance Company:

Subscriber's Name:	Subscriber's Soc. Sec. No.:	Birth Date: / /	Policy No:	Group No:	Co-payment: $

Patient's relationship to subscriber: ❒ Self ❒ Spouse ❒ Child ❒ Other

Name of secondary insurance (if applicable):	Subscriber's Name:	DOB: / /	Policy No:	Group No:

Patient's relationship to subscriber: ❒ Self ❒ Spouse ❒ Child ❒ Other

IN CASE OF EMERGENCY

Name of local friend or relative	Relationship to Patient:	Home Phone No.: ( )	Work Phone No.: ( )

Payment in full is required at the time of service. This includes co-pays, co-insurance and deductibles. All cosmetic procedures require payment in full prior to the date of the procedure. Our staff will work with you to obtain prior approval from your insurance carrier for services that are medically necessary.
Your signature below confirms your understanding of the above information.

_____ _____

Patient/Guardian Signature *Date*