PLASTIC SURGERY AESTHETICS, P.C. **REGISTRATION FORM**

New Patient Information Date: _____

Name:_____ Soc. Sec. #:_____

Address:_____City:_____State:_____Zip:_____

Cell Phone#_____ Home Phone#_____ Email_____

Sex: ___M ___F Age:_____ Birth Date:_____ ___Single ___Married ___Widowed ___Divorced

How would you prefer to be contacted? _____ Cell# _____ Home# _____ Email

Patient Employed by:_____ Occupation:_____

Business Address:_____ Business Phone:_____

Whom may we thank for referring you:_____

In case of emergency who should be notified:_____

Phone:_____ Relationship: _____

Primary Insurance ~ Not Applicable for Cosmetic Cases

Person Responsible for Account:_____
Relation to Patient:_____ Birth date:_____ Soc. Sec#:_____
Address (if different from patient):_____ Phone:_____
City:_____ State:_____ Zip:_____ Effective Date: _____
Person Responsible Employed by:_____Occupation:_____
Business Address:_____Phone:_____
Insurance Company:_____
Insurance Phone #:_____ Group #:_____ Subscriber #:_____

Additional Insurance: ~ Not Applicable for Cosmetic Cases

Is patient covered by additional insurance? _____Yes _____No_____
Subscriber Name:_____ Relation to Patient:_____ Birth date:_____
Address (if different from patient):_____ Phone:_____
City:_____ State:_____ Zip:_____ Effective Date: _____
Person Responsible Employed by:_____Occupation:_____
Business Address:_____Phone:_____
Insurance Company:_____
Insurance Phone #:_____Group #:_____Subscriber #:_____

Assignment and Release

I, the undersigned certify that I (or my dependent) have insurance coverage with_____
(name of insurance)
and assign directly to Dr. Erin M. Kennedy (Plastic Surgery Aesthetics, P.C.) all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____ _____ _____
Responsible party signature Relationship Date