LOWCOUNTRY PLASTIC SURGERY CENTER, LLC

Registration Information

PATIENT INFORMATION

Name: _____ Social Security Number: _____

Birthdate: _____ Age: _____ Driver's License Number: _____

Address: _____ Home Phone: _____

City, State, Zip: _____ Cellular Phone: _____

E-mail address _____

Are you a student? _____ If yes, are you full time _____ Marital Status: S M D Sep W

Employer: _____ Occupation: _____ FT PT

Employer Address: _____ Work Phone: _____

City, State, Zip: _____ Alternate Phone: _____

Referral Source: ____BellSouth YP ____BellSouth Mt Pleasant YP Newspaper ad _____
____The Talking YP ____The Talking YP Mt Pleasant Friend _____
____Emergency Room ____Internet Physician _____

INSURED/RESPONSIBLE PARTY INFORMATION

Name: _____ Relationship to Patient: _____

Birthdate: _____ Age: _____ Social Security Number: _____

Address: _____ Home Phone: _____

City, State, Zip: _____

Employer: _____ Occupation: _____

Employer Address: _____ Work Phone: _____

_____ Alternate Phone: _____

PRIMARY INSURANCE INFORMATION

Insurance Company: _____ Policy Holder's Name: _____

Policy Number: _____ Group Number: _____

Address: _____ Phone Number: _____

City, State, Zip: _____ Fax Number: _____

SECONDARY INSURANCE INFORMATION

Insurance Company: _____ Policy Holder's Name: _____

Policy Number: _____ Group Number: _____

Address: _____ Phone Number: _____

City, State, Zip: _____ Fax Number: _____

Do you have another health benefit plan? No Yes _____

EMERGENCY CONTACT INFORMATION (Someone who does not live with you)

In case of emergency, notify: _____

Relationship: _____ Phone Number(s): _____

I authorize you to give me reasonable and proper medical care by today's standards. I, the patient or responsible party, authorize release of medical information for the purpose of processing medical claims.

SIGNATURE: _____ **DATE:** _____