

# REGIONAL PHYSICIANS PLASTIC SURGERY

1011 N. Lindsay Street, Suite 202 High Point, NC 27262

Phone: (336) 886-1667 Fax: (336) 886-5536

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## PATIENT INFORMATION

Social Security No.: \_\_\_\_\_ Patient's Full Legal Name: \_\_\_\_\_

( First Middle Last)

Sex: \_\_\_F \_\_\_M Birth Date \_\_\_/\_\_\_/\_\_\_ Age: \_\_\_ Race: \_\_\_\_\_ Spoken Language: \_\_\_\_\_

Marital Status: Single \_\_\_ Married \_\_\_ Widowed \_\_\_ Divorced \_\_\_ Separated \_\_\_

Address: \_\_\_\_\_  
Street City State Zip Code

Employer: \_\_\_\_\_ Address: \_\_\_\_\_

Home Phone: ( ) \_\_\_\_\_ Work Phone: ( ) \_\_\_\_\_ Cell Phone: ( ) \_\_\_\_\_

Email: \_\_\_\_\_ Referring Provider Name: \_\_\_\_\_

How did you hear about us? (circle the one that applies) Family / Friend / Insurance / Employer/ Internet / Website/Billboard/  
Hospital/ Mini Gastric Bypass/ Newspaper /Mailer /Radio /Doctor /Seminar/Special Event / Sports Team Support / TV  
/Worker's Comp / Online Yellow Pages / Yellow Pages

Primary Insurance: \_\_\_\_\_ Subscriber ID: \_\_\_\_\_

Subscriber Name: \_\_\_\_\_ Group #: \_\_\_\_\_

Subscriber's Soc. Sec. #: \_\_\_\_\_ Subscriber's Date of Birth: \_\_\_\_\_

Secondary Insurance: \_\_\_\_\_ Subscriber ID: \_\_\_\_\_

Subscriber Name: \_\_\_\_\_ Group #: \_\_\_\_\_

Subscriber's Soc. Sec. #: \_\_\_\_\_ Subscriber's Date of Birth: \_\_\_\_\_

\*\*\*Please have your insurance card(s) and photo ID ready to be copied.\*\*\*

Spouse's Name: \_\_\_\_\_ Work Phone: ( ) \_\_\_\_\_ Cell Phone ( ) \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_

Home Phone: ( ) \_\_\_\_\_ Work: ( ) \_\_\_\_\_ Cell: ( ) \_\_\_\_\_

**IF PATIENT IS UNDER 18 YEARS OLD, PLEASE COMPLETE PARENT/GUARDIAN SECTION BELOW.**

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Parent/Guardian Name: \_\_\_\_\_

Address: \_\_\_\_\_

(if different from above) Street City State Zip Code

Home Phone: ( ) \_\_\_\_\_ Work: ( ) \_\_\_\_\_ Cell: ( ) \_\_\_\_\_

Social Security #: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Sex: \_\_\_F \_\_\_M

Marital Status: Single \_\_\_ Married \_\_\_ Widowed \_\_\_ Divorced \_\_\_ Separated \_\_\_

The undersigned makes the following acknowledgments and agreements regarding treatment to be provided to the patient whose name appears above:

1 – **Consent to treatment:** I consent to any medical or surgical treatment rendered to the patient under general or special instructions of the physician. I certify that no guarantee of assurance has been made to me as to the results which may be obtained.

2 – **Release of medical information:** I authorize the release of any medical or other information from this provider and other providers necessary to process a health insurance claim or to provide treatment.

3 – **Assignment of benefits:** I authorize payment of medical benefits to MedVentures, LLC DBA Regional Physicians.

I certify that the information given at the time of registration is correct. I understand that I will be financially responsible for all charges in full at the time I am given treatment unless otherwise discussed before I am seen. I understand I am financially responsible to Regional Physicians for charges not covered by insurance.

\_\_\_\_\_  
Signature of Patient or Legal Representative

\_\_\_\_\_  
Date

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