BERKS PLASTIC SURGERY
PATIENT REGISTRATION FORM

Patient's Name: ______________________________ Sex: __________

Street Address: ______________________________

City: ____________________ State: ______________ Zip Code: ______________

Social Security Number: ______________ Date of Birth: ______________ Age: __________

Marital Status (check one): ❑ Minor ❑ Single ❑ Married ❑ Divorced ❑ Separated ❑ Widow(er)

If a minor, give parents and / or legal guardian's names: ______________________________

Minor resides with: ______________________________ **

**Note: Custodial Parent / Guardian receives all correspondence and billing information from this office.

Home Phone: ______________ Cell Phone: ______________ E-Mail: ______________________

Patient's (or custodial parent / guardian's) Employer: ______________________ Work Phone: ______________

Spouse's Name: ______________________ Spouse's Employer: ______________________

Spouse's Work Phone: ______________________ Spouse's Cell Phone: ______________________

Person to Contact in Case of Emergency: ______________________ Phone: ______________

Reason for Office Visit: ______________________________

Family Doctor: ______________________________ Phone: ______________

Referred By: ______________________________ Phone (if doctor): ______________

OR How did you hear about us? (check one) ❑ Newspaper ❑ Radio ❑ Yellow Pages ❑ Internet ❑ Other: __________

Is this a work related injury? ❑ Yes ❑ No   Is this an auto related injury? ❑ Yes ❑ No

HEALTH INSURANCE INFORMATION

(Reconstructive Patients Only)

Primary Health Insurance: ______________________________

Identification Number: ______________________ Group Number: ______________________

Insured's Name: ______________________ Relationship to Patient: ______________________

Insured's Date of Birth: ______________________ Insured's Employer: ______________________

Secondary Health Insurance: ______________________________

Identification Number: ______________________ Group Number: ______________________

Insured's Name: ______________________ Relationship to Patient: ______________________

Insured's Date of Birth: ______________________ Insured's Employer: ______________________

ASSIGNMENT AND RELEASE: I understand that I am financially responsible for all services. I hereby authorize release of any information concerning my (or my child's) health care, advice and treatment provided, for the purpose of evaluating and administrating claims for insurance benefits. I also hereby authorize payment of insurance benefits otherwise payable to me, to be paid directly to Berks Plastic Surgery.

Signed: ______________________________ Date: ______________________

Signature of Patient or Parent / Guardian if Minor