Patient Insurance Registration Form

Last Name: ____________________________ First Name: _______________________ M.I.: _____

Address: ____ Apt.#: _____________

City: __________________________________ State: ___________________ Zip: _______________

Home Ph: (____) ________________ Work Ph: (____) _____________ Other: (____) _______________

Date of Birth: _______/_______/_______ S.S. # _________ - _______ - _________

Sex: M / F Martial Status: Single / Married / Divorced / Widowed

E-Mail Address: ____
(please fill in to receive our monthly email specials)

Reason for Seeing Doctor:____

PCP or Referring Doctor:_____________________________ Date of Injury: _______/_______/_______

How were you referred?____

Insured (ONLY-If using insurance coverage):

Relationship to Patient: Self / Spouse / Child / Student

Last Name: _____________________________ First Name: _______________________ M.I.: ______

Address: ____ Apt.#: _____________

City: __________________________________ State: ___________________ Zip: _______________

Home Ph: (____) _______________________ Work Ph: (____) _______________________________

Date of Birth: _______/_______/_______ S.S. # _________ - _______ - _________

Sex: M / F Martial Status: Single / Married / Divorced / Widowed

Assignment of Benefits if using Insurance Benefits

I hereby authorize payment for medical benefits directly to Hall Plastic Surgery and Rejuvenation Center and if necessary the release of any pertinent medical information to insurance carriers. I also agree to pay any co-insurance, deductibles or non-covered expenses upon receipt.

Signature ______________________________ Date ____