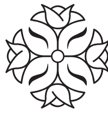

Chart # ___________

RALEIGH PLASTIC SURGERY
center

PATIENT INFORMATION

Are you a new patient? __________ How did you learn about our office? ______________________________

Patient's Name: ______________________________ Birthdate: ___/___/___ Age: ________ Sex: ________
Last First Middle M D YR

Patient's Address: ____
Street Apt# City State Zip Code

Patient's SS# ________________ Phone (H): ______________ (WK): ______________ ext. _____ Cell ______________

At which number may we reach you? ❑ Home ❑ Work ❑ Cell E-mail ______________________________

Preferred Pharmacy: ______________________ Location: ______________________________

Race:
- ❑ (1) Asian or Pacific Islander
- ❑ (3) Caucasian
- ❑ (5) American Indian or Alaskan Native
- ❑ (6) Black or African American
- ❑ (9) Other

Ethnicity:
- ❑ (1) Non-Hispanic
- ❑ (2) Hispanic
- ❑ (9) Declined/Unavailable

Preferred Language: ______________________________

Emergency Contact: ______________________ Phone: ________________ Cell ________________

Relation: ______________________________

Receive information regarding special offers? ❑ Yes ❑ No

Is this a work related injury? ❑ Yes ❑ No

If yes, Employer Name and Contact Number: ______________________________________

Are you the Primary Insurance Holder? ❑ Yes ❑ No

If you checked NO, information below MUST be completed.

Primary Policy Holders Name: ____________________ **Policy #** ____________________ **DOB:** ____________

Employer: ____

PRIVACY POLICIES NOTICE ACKNOWLEDGEMENT, IN ACCORDANCE WITH THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPAA)

I ________________________ acknowledge that a copy of RPSC, Inc.'s Privacy Policies Notice has been made available to me in accordance with the Health Insurance Portability And Accountability Act of 1996 (HIPAA).

Signed ____ Date ________________
(Patient Signature or Responsible Party)

Authorization and Assignment

I hereby authorize Raleigh Plastic Surgery Center, Inc. to furnish all necessary information to appropriate parties such as insurance carriers, physicians, and attorneys concerning treatments rendered. I understand that I am responsible for ALL medical expenses whether or not there is insurance coverage (and/or ANY expenses incurred as a result of collecting a past due account). I understand that payment for office visits is due the day of service and if insurance submitted for surgical services is not paid by 60 days, I must pay in full unless arrangements are made.

Patient (or legal representative) Signature: ______________________________ Date: ____________

Relationship to Patient (if legal rep.) ______________________________