PATIENT REGISTRATION

First **Last** **M.I.** **M F**

Street Address **City** **State** **Zip**

Home Phone **Work Phone** **Cell Phone**

Email Address **Social Security Number** **Date Of Birth** **Age**

Primary Insurance (complete ONLY for non-cosmetic procedures)

Policy Holder Name **Social Security Number**

Date of Birth **Relationship to Patient** **Home Phone (if different from patient)**

Secondary Insurance

Policy Holder Name **Social Security Number**

Date of Birth **Relationship to Patient** **Home Phone (if different from patient)**

Please tell us how you heard about our office? Please Circle one. Friend_____
Internet: ASPS (Plastic Surgery.org) Consumer's Guide to Plastic Surgery.___Other_____
Radio Yellow Pages User Friendly Phone Book Other_____
Magazine _____ Newspaper _____

Would you like to be contacted by mail ___ e-mail ____ both ____ regarding special offers?
Please do not contact _____
May we leave messages at your home regarding your care? _____

It is the practice of Western Reserve Plastic Surgery, Inc., to collect cosmetic consultation fees at the time of service or to bill your insurance company with regards to any procedure that is considered to be medically necessary, however in the event that said insurance company should deny the claim it becomes the responsibility of the patient to make payment or payment arrangements within 90 days of the insurance companies denial. I authorize the release of any medical information necessary to process my insurance claim. I subsequently authorize payment of medical benefits directly to Western Reserve Plastic Surgery. By signing this agreement I acknowledge the financial responsibility of Western Reserve Plastic surgery and myself.

Signature of Responsible Party **Date**