REGISTRATION
(Please Print)

SMITH PLASTIC SURGERY

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16 OKATIE CENTER BLVD. SOUTH, SUITE 101
OKATIE, SC 29909

DATE: ____________________________ **CONTACT PHONE #'S:** (_____) ____________ (_____) ______________

PATIENT INFORMATION

Name: ____ Soc. Sec #: ___________________________________
Last Name First Name Initial
Address: ____
City: ____ State: ______________ Zip: _________________
Sex: j M j F Age: _________ Birthdate: _________________
Marital Status: j Single j Married j Widowed j Separated j Divorced
Patient Employed By: ____ Occupation: _______________________
Business Address: ____
City: ____ State: _______________ Zip: ____________
Business Phone: (________)____________________________ E-mail: ____________________________________
Were you injured on the job? : ______________________ Were you injured in an auto accident? : _____________________
Date you were injured? : _____________________________
How did you get the name of our office? ____
EMERGENCY CONTACT: ____________________________ Relationship:__________ Phone: (____)________________

PRIMARY INSURANCE

Person Responsible for Account: ____
Last Name First Name Initial
Relation to Patient: ____________________ Birthdate: _________________ Soc Sec #: ______________________________
Address (If different from patient's): ______________________________________ Phone: (____)_____________________
City: ____ State: ____________ Zip: ___________________
Person Responsible Employed By: _____________________________________ Occupation: _________________________
Business Address: ____ Phone: (____)_________________
Insurance Company: _______________________________________ Subscriber #: __________________________________
Contract #: ________________________ Group #: ____________________

ADDITIONAL INSURANCE

Is the patient covered by additional insurance? j Yes j No
Subscriber Name: _________________________________ Relation to Patient________________ Birth Date: ____________
Address (If different from patient's): ____ Phone (_____)_________________
City: ____ State: _____________ Zip: ________________
Insurance Company: ____ Subscriber #: _______________________________
Contract #: _______________________________ Group #: _________________________

I hereby authorize the release of medical record information to my insurance company, its assigns, representatives, or any physician or medical facility providing medical care. I also authorize my insurance company to pay any benefits payable under my policy to Smith Plastic Surgery. By signing below I acknowledge that I am financially responsible for all charges incurred whether or not paid by my insurance company.

____ ____
PATIENT SIGNATURE DATE

____
RELATIONSHIP TO PATIENT

FINANCIAL POLICY OF SMITH PLASTIC SURGERY

Smith Plastic Surgery is committed to providing you the best possible care, and we are pleased to discuss our professional fees with you at any time. Your clear understanding of our Financial Policy is important to our professional relationship. Please ask us if you have any questions about our fees, financial policy, or your responsibility.

Full payment is expected at the time the service is rendered unless you have health care coverage through a plan with which the physician participates. In this case, all patient deductibles, co-payments, coinsurance and/or non-covered services are due at the time of service. **Co-payments are to be paid at the time of check-in. If your co-payment cannot be paid at the time of your visit, your appointment will need to be rescheduled.**

Smith Plastic Surgery accepts cash, checks, MasterCard/Visa, and American Express as payment for services rendered. **Cosmetic procedures and injections are to be paid at the time services are rendered.**

If surgery is recommended, you must pay any deductible and/or co-payment, which have not been satisfied at the time your surgery is scheduled. If you are having a cosmetic procedure, a $500.00 deposit is required at the time of scheduling your procedure and the entire balance is due 14 days prior to your actual surgery date. If you do not have insurance coverage, you will be required to pay for your procedure in full prior to your procedure being performed.

If you have been involved in an automobile accident, please know that we **DO NOT GET INVOLVED IN ANY THIRD PARTY LITIGATION.** Any money that you receive from an automobile insurance policy will be between you and the insurance company.

As our services are provided to you, not your insurance company, payment for service is your responsibility. Therefore, all charges that are filed to your insurance carrier and are not paid within 60 days from the date of filing become your responsibility.

All new patients are asked to complete our "Patient Registration Form" prior to seeing the physician. We request our established patients inform us of any changes in his/her name, address, telephone number, employer and/or insurance status. We will verify this information with you at each visit.

Please verify your insurance coverage and bring your insurance card(s) to our office each time you visit.

If it becomes necessary for your account to be placed in collections due to nonpayment, the patient and/or guarantor are responsible for all associated collection costs.

Thank you for understanding our Financial Policy. We appreciate your compliance with this policy. Please let us know if you have any questions or concerns regarding this policy.

Patient/Guarantor Signature____

Relationship to Patient______________________________ Date: _____________________

Witness ____ Date: _____________________

HEALTH HISTORY

Please Complete This Form **Entirely**

Reason for your office visit today: ____________________

Condition			Condition			Condition		
Anemia	Y	N	Anesthesia Sensitivity	Y	N	Hepatitis	Y	N
Arthritis	Y	N	Heart Disease	Y	N	Liver Disease	Y	N
Asthma	Y	N	High Blood Pressure	Y	N	Kidney Disease	Y	N
Bladder Infections	Y	N	Heart Attack	Y	N	Thyroid Disease	Y	N
Bleeding Disorders	Y	N	Mitral Valve Prolapse	Y	N	Tuberculosis	Y	N
Breathing/Lung Problems	Y	N	Diabetes	Y	N	Psychiatric/Emotional	Y	N
Bronchitis	Y	N	Stroke	Y	N	Ulcer	Y	N
Cancer - Where?	Y	N	Glaucoma	Y	N	HIV/AIDS	Y	N
Chemo/Radiation	Y	N	Hernia	Y	N	Venereal Disease	Y	N
Fever Blisters	Y	N	Hives/Eczema	Y	N	Epilepsy	Y	N
Intestinal Disorder	Y	N						

If you answered yes to any of the above questions, please elaborate: ____________________

____

Please list any other disease/condition/chronic illness not listed above: ____________________

____

Allergies (Medication, Food, Topical, Environmental):____________________

Please list ALL medications you are currently taking including non-prescription medications & vitamins:

____

____

Have you ever been hospitalized or undergone any type of surgery? Please list:____________________

____

____

Have you ever had any type of reaction to anesthesia (local, general, conscious sedation)?__________

Primary Care Physician: ____________________ Phone: ____________________

Height:________ Weight:________ Smoking History:__________ Alcohol:__________

Caffeine: __________ Recreational Drugs:__________

Family History

Has any blood relative had any of the following?

			Relationship				Relationship
Cancer	Y	N		Stroke	Y	N	
Diabetes	Y	N		Epilepsy	Y	N	
Heart Disease	Y	N		Anemia	Y	N	
High Blood Pressure	Y	N		Bleeding Disorder	Y	N	

Patient Signature: ____________________ Date: ____________________