PLASTIC SURGEONS OF NORTHERN ARIZONA

PATIENT REGISTRATION (Please Print Legibly)

PATIENT INFORMATION

Patient's Legal Name____ ____________________
Last First Middle Nickname Social Security Number

Date of Birth____________________ ___________ Sex_______ Marital Status______________________
Month Day Year Age

Patient's **Mailing Address**____
City State Zip

Patient's **Actual Address** ____
(If Different from above) City State Zip

Home Phone____________________Cell______________E-Mail______________________________

Employer______________________________________Work Phone___________________________

Employer
Address____
Street City State Zip

Family Physician_______________________________**Referred by**____________________________

In Case of Emergency, Notify____

INSURANCE INFORMATION (COPY OF CARD IS REQUIRED)

Primary Ins. Name____

Group Insurance /Company Name____

Insured Name_________________________**DOB**_________________**Sex**_______

Secondary Insurance Name____

Group Insurance/Company Name____

Insured Name_________________________**DOB**_________________**Sex**_______

RESPONSIBLE PARTY IF DIFFERENT FROM ABOVE

Name_______________________________Home Phone__________________Work Phone__________

Address____DOB_________________

SS#_________________________Relationship to Patient______________________________________

Employer_______________________________Employer Address__________________________________

WORKMAN'S COMPENSATION INFORMATION

Date of Injury___________ Claim #___________________ Insurance Carrier________________________

Employer______________________________________ Work Phone___________________________

Address____

AUTHORIZATION

I hereby authorize Plastics Surgeons of Northern Arizona (PSNA) to furnish information to insurance carriers concerning this illness/accident, and hereby irrevocably assign to PSNA all payments for medical services rendered. I understand that it is my responsibility to know the benefits provided by my insurance company, and that some services may not be covered by insurance. I understand that I am financially responsible for all charges whether or not covered by insurance, and that co-payments are due and payable at the time of service.

X____
Signature **Date**

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