

REGISTRATION
LONGWOOD PLASTIC SURGERY

Please fill out completely

Patient Name: _____

Address: _____

Telephone Number: _____ Cellular Phone No. _____

E-mail Address: _____

Date of Birth: _____ Social Security No.: _____

Marital Status: _____ Gender: Male Female

Employer: _____ Occupation: _____

Address: _____

Telephone Number: _____

Emergency Contact/Name: _____ Relationship: _____

Address: _____

Telephone Number: _____ Cell Phone Number: _____

Insurance Plan: _____

Address: _____ Telephone Number: _____

_____ Insurance I.D.: _____

Subscriber: _____ Group Number: _____

Primary Care Physician: _____ Telephone No.: _____

How were you referred to us? _____

WAIVER OF BENEFITS: I authorize Longwood Plastic Surgery, P.C., to submit claims to my insurance carrier(s) for services that they believe to be "covered services" and to receive payment directly on my behalf.

I understand that I am financially responsible for and agree to pay for any services furnished to me by Longwood Plastic Surgery, P.C. which are not covered by my insurance carrier(s).

I understand that I am financially responsible for and agree to pay for any services furnished to me by Longwood Plastic Surgery, P.C. as a result of my failure to obtain the necessary referral and/or other authorizations from my primary care and/or referring physicians when required.

Patient Signature

Date of Visit

05/08