REGISTRATION **Greater Milwaukee Plastic Surgeons, S.C.**

PATIENT INFORMATION *(please print & complete all areas)*

Name _____ **SSN** _____ - _____ - _____
(Last First MI)

Address _____ City _____ State _____ Zip _____

Home # (_____) _____ **Work #** (_____) _____ **Cell#** (_____) _____

* List only numbers we have your consent to call

☐ Male ☐ Female **Date of Birth** _____/_____/_____ ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Ethnicity ☐ African-American ☐ Asian ☐ Caucasian ☐ Hispanic ☐ Other **Age** _____

Employer _____ **Occupation** _____

Employer Address _____

Spouse's Name_____ **Spouse's Soc.Sec.#** _____ - _____ - _____

Spouse's Employer _____ **Date of Birth** _____/_____/_____

Referring Doctor's Name _____ **Primary Doctor's Name** _____

Emergency Contact _____ **Phone #** (_____) _____ **Relationship** _____

INSURANCE

Person Responsible for Account / Insured _____
(Last First MI)

Primary Insurance _____ **Secondary Insurance** _____

Policy Holder Name _____ **Policy Holder Name** _____

Subscriber # _____ **Subscriber #** _____

Group # _____ **Group #** _____

***** If patient is the <u>CHILD OF THE INSURED</u>, the parent's information must be completed below:***

SSN _____ - ____ - _____ DOB _____/_____/_____ Home # (_____) _____ Relationship _____

Address_____ City _____ State _____ Zip _____

Employer _____ Work # _____

ASSIGNMENT AND RELEASE

I certify that I (or my dependent) have insurance coverage with aforementioned insurance carrier(s) and assign directly to my doctor all insurance benefits, if any, otherwise payable to me for services rendered. ***I understand that I am financially responsible for all charges whether or not paid by my insurance and accept responsibility for any balance remaining after payment of such benefits.*** I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions. I further authorize the physician to release any information required in the course of my treatment as authorized according to HIPAA Privacy Rules.

_____ _____ _____
Signature of Insured or Guardian Relationship Date