Piedmont Plastic Surgery, PA

Patient's Full Legal Name: _____ **Date of Birth:** _____**Age**_____

Social Security Number: _____ **Sex: Male**____ **Female** ____

Marital Status (please circle one): SINGLE MARRIED WIDOWED DIVORCED SEPARATED

We are now required to collect Race, Ethnicity and Language. If you prefer not to report that information, you may choose Refused to Report/Unreported.

(Please Check ONE in EACH CATEGORY that applies)

R A C E		E T H N I C I T Y	PREFERRED LANGUAGE	
☐ White	☐ More Than One	☐ Hispanic or Latino	☐ English	☐ Hindi
☐ Black or African American	☐ Native Hawaiian	☐ Not Hispanic or Latino	☐ Spanish	☐ Vietnamese
☐ Asian	☑ Other Pacific Islander	☐ Refused to Report/Unreported	☐ Urdu	
☐ American Indian or Alaskan Native	☐ Undefined	☐ Undefined	☐ Refused to Report/Unreported	
☐ Refused to Report/Unreported			☐ Other	

Employer's Name: _____

Employer's Address: _____

Employer's Telephone Number: _____

PATIENT ADDRESS INFORMATION

Address: _____
Street City State Zip Code

Email address: _____

Home Phone: ( ) _____ **Work Phone: ( )**_____**ext** _____

Cell Phone: ( ) _____ **Spouse Name:**_____ **DOB:**_____

Primary Care Physician_____ **Referring Provider Name:**_____

HOW DID YOU HEAR ABOUT US? (Please Check all that apply)

☐Family/Friend	☑ Existing Patient	☐ Google rank	☐ Internet Search	☐ PPS Website
☐Hospital	☐ Newspaper	☐ FaceBook page	☐ Radio	☐ Doctor
☐Seminar-Special Event	☐ Self Referral	☐ Worker's Comp	☐ Magazine ad	☐ Other: _____

Pharmacy Name _____
Pharmacy Address _____

_____

Pharmacy Phone _____

The above information was updated on _____By_____(initials)

The above information was updated on _____By_____(initials)

The above information was updated on _____By_____(initials)

The above information was updated on _____By_____(initials)

Revised 11/14/19

Piedmont Plastic Surgery, PA

*****PLEASE HAVE YOUR INSURANCE CARD(S) AND PHOTO ID READY TO BE COPIED*****

GROUP INSURANCE INFORMATION

Primary Insurance:_____ **Member ID:**_____

Policyholder Name: _____ **Policyholder Date of Birth:**_____

Group #: _____**Patient's Relation to Policyholder: (CIRCLE ONE) Self Spouse Child Parent Other**

Secondary Insurance:_____ **Member ID:**_____

Policyholder Name: _____**Policyholder Date of Birth:** _____

Group #: _____**Patient's Relation to Subscriber: (CIRCLE ONE) Self Spouse Child Parent Other**

EMERGENCY CONTACT INFORMATION

Emergency Contact: _____**Relationship:** _____

Home Phone: ( )_____ **Work: ( )**_____ **Cell: ( )** _____

IF PATIENT IS UNDER 18 YEARS OLD, PLEASE COMPLETE PARENT/GUARDIAN/GUARANTOR SECTION BELOW

Parent/Guardian/Guarantor Name: _____

Address:_____

(if different from above) Street City State Zip Code

Home Phone: ( ) _____ **Work: ( )**_____ **Cell: ( )** _____

Social Security #: _____ **Date of Birth:** _____ **Sex: M** _____ **F** _____

Marital Status: (CIRCLE ONE) Single Married Widowed Divorced Separated

---

The undersigned makes the following acknowledgments and agreements regarding treatment to be provided to the patient whose name appears above:

1 – **Consent to treatment: I** consent to any medical or surgical treatment rendered to the patient under general or special instructions of the physician. I certify that no guarantee of assurance has been made to me as to the results which may be obtained.

2 – **Release of medical information: I** authorize the release of any medical or other information from this provider and other providers necessary to process a health insurance claim or to provide treatment.

3 – **Assignment of benefits: I** authorize payment of medical benefits to Piedmont Plastic Surgery, PA

4 – **Photograph/Internet consent form:** I hereby grant permission to Dr. Willard to take photographs of me to use for documentation in the doctor's records and/or to submit to my insurance carrier for prior authorization for surgery or for proof of disability. These photographs may also be used for educational purposes, i.e. publications, written or on the internet, and/or lectures, on a National, State and Local level and the Company website.. I consent to the use of my photographs as examples of work performed.

I certify that the information given at the time of registration is correct. I understand that I will be financially responsible for all charges in full at the time I am given treatment unless otherwise discussed before I am seen. I understand I am financially responsible to Piedmont Plastic Surgery PA for charges not covered by insurance.

_____ _____

Signature of Patient, Guardian or Legal Representative **Date**