

Coastal Plastic Surgery

Patient Registration Form

Patient Information:

Name (Last) _____ (First) _____ (Middle Init.) _____

Address(Street) _____ (City) _____ (State) _____ (Zip) _____

Home# _____ Cell _____ Work _____

*I authorize Dr.Adam's office staff to leave messages for me on: Home# Y / N Work# Y / N Cell# Y / N

Employer _____ Employers Address _____

Date of Birth _____ Social Sec.# _____ Sex _____ Marital Stat. _____ Spouse Name _____

May we e-mail you specials/promotional offers? Y / N E-Mail Address _____

*** Valid ID required for photocopy**

Responsible Party if other than "Self"(Name of the person responsible for payment if other than the patient):

Name (Last) _____ (First) _____ (Middle Init.) _____

Address(Street) _____ (City) _____ (State) _____ (Zip) _____

Home # _____ Cell _____ Work _____

Employer _____ Employers Address _____

Date of Birth _____ Social Security# _____ Sex _____

How did you hear about our facility? _____

Name of Referring Physician _____ **Phone #** _____

Emergency Contact _____ **Phone#** _____

Please note: We do not accept Worker's Compensation or 3rd party billing.

I understand Coastal Plastic Surgery accepts medical insurance for breast cancer related issues only, unless otherwise approved by Dr.Todd Adam himself. I will provide the insurance card to copy. I hereby assign, transfer, and set over to Dr.Todd Adam, all of my rights, title, and interest to my medical reimbursement benefits under my insurance policy if I am being treated for a medical diagnosis. I authorize the release of any medical information needed to determine these benefits. This authorization shall remain valid until I revoke this authorization with written notice. I understand that I am financially responsible for all charges whether or not they are covered by insurance.

Patient's Signature: _____ **Date:** _____