

# Parva Plastic Surgery

## Patient Registration Please Print or Type Clearly & Fill Out Completely

PATIENT NAME First Middle Last			SOCIAL SECURITY NUMBER		DATE OF BIRTH:		AGE
ADDRESS:			CITY		STATE	ZIP CODE	SEX
HOME PHONE ( )		CELL PHONE ( )		E-MAIL			
MARITAL STATUS <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widow(er)		EMPLOYER		WORK PHONE ( )			
EMPLOYER ADDRESS			CITY		STATE	ZIP CODE	
SPOUSE/PARENT NAME		HOME PHONE ( )		WORK PHONE ( )			
SPOUSE/PARENT ADDRESS			CITY		STATE	ZIP CODE	
REFERRING PHYSICIAN		PHYSICIAN PHONE					

### Policy Concerning Services Not Covered By Insurance

We request payment to be made at the time services are rendered. Any unpaid balances are due within 30 days of treatment date, unless other arrangements have been made. Payment is accepted in the form of cash, check, money order or credit card.

I agree to be responsible for costs and attorney fees associated with the collection of this account, as well as interest at the rate of 18% APR on all balances more than 30 days overdue.

Print Name \_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_\_

## Insurance Coverage and Billing Information

<b>PRIMARY INSURANCE</b>	INSURANCE COMPANY NAME			POLICYHOLDER NAME				
	POLICYHOLDER RELATIONSHIP TO PATIENT			POLICYHOLDER SOCIAL SECURITY NUMBER				
	POLICYHOLDER DATE OF BIRTH			POLICYHOLDER HOME PHONE ( )				
	POLICYHOLDER ADDRESS (if different from patient)			CITY		STATE	ZIP CODE	
	POLICYHOLDER EMPLOYER			POLICYHOLDER WORK PHONE ( )				
<b>SECONDARY INSURANCE</b>	INSURANCE COMPANY NAME			POLICYHOLDER NAME				
	POLICYHOLDER RELATIONSHIP TO PATIENT			POLICYHOLDER SOCIAL SECURITY NUMBER				
	POLICYHOLDER DATE OF BIRTH			POLICYHOLDER HOME PHONE ( )				
	POLICYHOLDER ADDRESS (if different from patient)			CITY		STATE	ZIP CODE	
	POLICYHOLDER EMPLOYER			POLICYHOLDER WORK PHONE ( )				

### Release of Information and Assignment of Benefits

I hereby authorize and direct my insurance carrier to pay directly to Parva Plastic Surgery, benefits due to me under my insurance plan. I agree to pay any balance not paid under this plan.

I hereby authorize Parva Plastic Surgery to release to my insurance company any medical information necessary to process any claims.

My insurance  does or  does not require referrals, authorization numbers or telephone referrals by my primary care physician. I know that if I agree to be treated without a referral/authorization, if required, I will be held financially responsible for any charges not paid by my health insurance carrier.

I agree to be responsible for costs and attorney fees associated with the collection of this account, as well as interest at the rate of 18% APR.

Print Name \_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_\_

# Parva Plastic Surgery Center, P.C.

## HISTORY & PHYSICAL FORM

### PLEASE ANSWER ALL QUESTIONS

NAME: \_\_\_\_\_  
(First, Middle, Last)

DATE: \_\_\_\_\_

Age: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Marital Status: \_\_\_\_\_

Occupation: \_\_\_\_\_

*Please List*

ALLERGIES (Medications/Latex/Other): \_\_\_\_\_

How did you hear about our practice?

Specific reason for seeing a plastic surgeon: \_\_\_\_\_

Referred by: \_\_\_\_\_

Family Physician: \_\_\_\_\_

Newspaper/Radio/Phone Book-which one

Pregnant: Times: \_\_\_\_\_ Live Births: \_\_\_\_\_

### PAST MEDICAL HISTORY:

General Health:  Good  Fair  Poor

### PRESENT MEDICATIONS:

Height \_\_\_\_\_ Weight \_\_\_\_\_

### HAVE YOU EVER HAD?

(Circle and What Year)

Heart Attack	Yes	No
Irregular Heartbeat	Yes	No
Heart Failure	Yes	No
Stroke	Yes	No
High Blood Pressure	Yes	No
Diabetes	Yes	No
Kidney Disease	Yes	No
Emphysema/COPD	Yes	No
Tuberculosis	Yes	No
Jaundice	Yes	No
Hepatitis	Yes	No

Epilepsy/Seizures	Yes	No
Abnormal Bleeding	Yes	No
Anemia	Yes	No
Rheumatoid Arthritis	Yes	No
Lupus Erythematosus	Yes	No
Scleroderma	Yes	No
Skin Sensitivities	Yes	No
Anesthetic Reaction	Yes	No
Prior Blood Transfusion	Yes	No
Cancer	Yes	No

If yes, of what? \_\_\_\_\_

Radiation Treatment Yes No

Alcohol Use Never/Occasional/Heavy

Smoking Yes No

Please note family history of any conditions above \_\_\_\_\_

### SURGICAL HISTORY

	Procedure	Date	Surgeon	Hospital
1.	_____	_____	_____	_____
2.	_____	_____	_____	_____
3.	_____	_____	_____	_____
4.	_____	_____	_____	_____

SIGNATURE: \_\_\_\_\_

DATE: \_\_\_\_\_