DAVID R. STEPHENS, MD
CENTER FOR PLASTIC SURGERY
PATIENT REGISTRATION

PATIENT'S NAME: ________________________ **HOME PHONE:** ____________________ **OK TO CALL** ☐

ADDRESS: ________________________ **WORK PHONE:** ____________________ **OK TO CALL** ☐

________________________ **CELL PHONE:** ____________________ **OK TO CALL** ☐

CITY STATE ZIP

EMAIL? ____________________@____________________ **MAY WE CONTACT YOU BY MAIL? YES** ❑ **NO** ❑

SEX: ☐ MALE ☐ FEMALE **MARITAL STATUS:** ☐ SINGLE ☐ MARRIED ☐ WIDOWED ☐ SEPARATED ☐ DIVORCED

SOC. SEC. #: ____________________ **BIRTH DATE:** ____________________ **AGE:** __________

DO YOU HAVE A LIVING WILL OR ADVANCED MEDICAL DIRECTIVE? ☐ YES ☐ NO

CONSULTATION FOR: ____

REFERRED TO THIS OFFICE BY: ____

PATIENT'S EMPLOYER: ____________________

ADDRESS: ____________________

OCCUPATION: ____________________

SPOUSE'S NAME: ____________________

SPOUSE'S EMPLOYER: ____________________

WORK PHONE: ____________________

PERSON RESPONSIBLE FOR BILL, IF NOT PATIENT:

☐ SPOUSE ☐ PARENT ☐ OTHER

NAME: ____________________

ADDRESS: ____________________

____

HOME PHONE: ____________________

EMPLOYER: ____________________

ADDRESS: ____________________

____

WORK PHONE: ____________________

INSURANCE INFORMATION: (MEDICAL ONLY)

INSURANCE

COMPANY: ____________________

SUBSCRIBER'S NAME: ____________________

DATE OF BIRTH: __________ **GROUP #:** __________

ID #: ____________________

SUBSCRIBER'S EMPLOYER: ____________________

PATIENT'S RELATIONSHIP TO SUBSCRIBER:

☐ SELF ☐ SPOUSE ☐ CHILD ☐ DEPENDENT

PRIMARY CARE PHYSICIAN INFORMATION:

NAME: ____________________

ADDRESS: ____________________

____

PHONE #: ____________________

IN CASE OF EMERGENCY, LOCAL FRIEND OR RELATIVE TO BE NOTIFIED (NOT LIVING AT SAME ADDRESS):

NAME: ________________________________ **RELATIONSHIP TO PATIENT:** ____________

HOME PHONE: ____________________ **WORK PHONE:** ____________________

ASSIGNMENT AND RELEASE: I hereby authorize my insurance benefits to be paid directly to the physician. I am financially responsible for any balance due. I also authorize the doctor or Insurance Company to release any information required for this claim. I have received and read the Notice of Privacy Practices information sheet provided for me by Dr. Stephens' office.

SIGNED: ________________________________ **DATE SIGNED:** ____________