# WESTFIELD PLASTIC SURGERY - PATIENT REGISTRATION FORM

**DATE _____**

## PATIENT INFORMATION

PATIENT NAME _____ DATE OF BIRTH _____
First Middle Initial Last
SS# _____ AGE _____ SEX _____ **PRIMARY CARE PHYSICIAN** _____

HOME ADDRESS _____
Street Address City State Zip
HOME PHONE _____ WORK PHONE _____ CELL PHONE _____

EMAIL ADDRESS _____

EMERGENCY CONTACT _____
Name Phone # Relationship

EMPLOYER _____
Name Street Address City State Zip Phone #

Employment Status: ☐ Full-Time ☐ Part-Time ☐ Not Employed ☐ Self Employed

IS YOUR VISIT TODAY THE RESULT OF AN ACCIDENT? ☐ Yes ☐ No IF YES, WHAT WAS THE DATE OF YOUR INJURY?_____

## (POLICY HOLDER) PRIMARY INSURANCE INFORMATION

INSURED'S NAME _____ DATE OF BIRTH _____ SS# _____

INSURANCE COMPANY NAME _____ (____ **DOES YOUR INSURANCE CARD HAVE "REFERRALS REQUIRED" printed on the Front?)**

WCOMP CASE MANAGER NAME: _____ PHONE NUMBER: _____

A. **Notice of Privacy Practices**. The policies and procedures of Westfield Plastic Surgery are designed to comply with the Health Insurance Portability and Accountability Act of 1996. I agree that the Privacy Notice of Westfield Plastic Surgery has been made available to me.

B. **Authorization to Treat**. I authorize and direct the medical practitioners of Westfield Plastic Surgery and his/her designee to provide medical services and diagnostic services for me as they deem necessary and appropriate. I understand that I have the right to receive information, to request treatment, and to seek a second opinion. Patients 18 years and younger must be accompanied by guardian.

C. **Assignment of Insurance Benefits.** I hereby assign all medical insurance benefits, to include major medical benefits to which I am entitled, including Medicare, private insurance and any other health plans to Westfield Plastic Surgery. I understand that I am financially responsible for co-payments, co-insurance, deductibles, and any other balance not paid for by my insurance plan.

The undersigned patient or patient's guardian hereby acknowledges to have read, understood and agreed to conditions set forth in the Notice of Privacy Practices, Authorization to Treat, Assignment of Insurance Benefits, and, if applicable, Medicare Patient's Information.

_____ _____
Signature of Patient or Legal Guardian Date

_____ _____
Printed name of Patient

**ETHNICITY (** ____Black or African American) ( ____Hispanic) ( ____White) (____American Indian or Alaskan Native) (____Asian) (____Other)

**Your PHARMACY_____ LOCATION_____**

**HOW DID YOU HEAR ABOUT US ??** (___ Doctor If Doctor Referral (Name)_____ )

(___Family) (___Friend) (___Radio) (___Magazine) (__ Patient) ( ___Insurance Co. Representative Provider List)

( **Online**- ___Google ___Westfieldpsc.com ___Real Self ___Build My Bod ___Other) (___ Other_____)