Elizabeth Clanton, MD

PEDIATRIC & ADULT PLASTIC & RECONSTRUCTIVE SURGERY

REGISTRATION FORM

Today's Date:

PATIENT INFORMATION

Patient's last name: First: Middle: Marital Status: [Circle One] Single Married Divorced Widowed

Address: City, State, Zip Code Birth date: Age: Sex:

☐ M ☐ F

Social Security Number: Home phone number: Cell phone number:

Your Email Address: Pharmacy Name: Pharmacy Address or Phone Number:

Your Primary Care Physician Name & Phone Number:

The Doctor who referred you Name & Phone Number:

INSURANCE INFORMATION

Person responsible for bill: Birth date: Address (if different): Home phone no.:

Is this person a patient here? ☐ Yes ☐ No Is this patient covered by insurance? ☐ Yes ☐ No

Name of **Primary Insurance**: Policy Number: Group Number: Subscriber's name: Subscriber's DOB:

Patient's relationship to subscriber: [Circle One] SELF SPOUSE CHILD

Name of **Secondary Insurance** (if applicable): Policy number: Group number: Subscriber's name:

Patient's relationship to subscriber: [Circle One] SELF SPOUSE CHILD

IN CASE OF EMERGENCY

Name of friend or relative: Relationship to patient: Home phone no.:

Is there any privacy concerns we should be aware of? If so, please explain:

_____

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Elizabeth Clanton, MD or insurance company to release any information required to process my claims.

Patient/Guardian signature Date