Plastic & Reconstructive Surgery, PC

1303 Sunset Drive Suite 5
Johnson City, TN 37604
Phone: 423/283-0323

438 E. Vann Road, Suite 200
Greeneville, TN 37743
423/278-1827

In order to serve you properly, we will nee the following information. .All information will be confidential. Contact the receptionist if you have any questions.

PLEASE PRINT

Patient name: ________________ ____ ____________________ **Gender:** M F **DOB:** __________
First MI Last

Marital Status: ____ **Race:** ________ **Ethnicity:** __________ **Language:** __________ **Dominant Hand:** R L

SS#: ________________ **Employer:** ______________________________

Primary Address: __________________________ **City:** ________________ **State:** ____ **Zip:** ______

Contact Information: ______________ ______________ ______________ ______________
Home Phone **Work Phone** **Cell Phone** **E-Mail**

Referred by: (please circle) Physician, Family, Friend, Yellow Pages, Website

Name & Phone Number of someone who does not live with you who we may notify in case of an emergency:

Name: ________________________ **Phone:** ______________ **Relationship to you:** __________

Pharmacy used: Name________________ **Address:** ________________________ **Phone:** __________

I hereby authorize Plastic & Reconstructive surgery, PC to download my medication history. ______ **(please initial)**

INSURANCE INFORMATION

Primary Insurance: ____________________ **Name of Insured:** ____________________________

Relationship to patient: __________ **Insured DOB:** ______ **Insured S.S.#** __________

Insured ID#: ________________ **Group #:** ____________ **Insured Employer:** ______________

Secondary Insurance: ____________________ **Name of Insured:** ____________________________

Relationship to patient: ______________ **Insured DOB:** ________ **Insured S.S.#** ______________

Insured ID#: ________________ **Group #:** ____________**Insured Employer:** ______________

Is your illness a result of an accident? Circle: Yes or No

If yes, what type of accident? Auto ____ Work ____ Other ______________ **Date of Injury:** __________

Responsible Party: ________________________ **Do you have an attorney: Circle: Yes or No**

Attorney name and telephone number: ____

I authorize release of any information that I have provided or related to my treatment or the treatment of my child, for the purpose of evaluating and administering claims for insurance benefits. I also assign any payment of insurance benefits to be paid to the treating physician and understand that any costs incurred on my behalf or that of my child that are not paid by insurance are my responsibility.
I acknowledge that the HIPAA policies of Plastic & Reconstructive Surgery PC have been made available to me.
I have been given the opportunity to ask questions concerning these policies and have been offered a personal copy.

Signature: ________________________ **Relationship to patient:** ______________ **Date:** ______

***If patient is under 18 years old ,this must be signed by a parent, legal guardian or person with Power of Attorney for patient's medical care. A copy of the legal document authorizing this must be presented for us to be able to treat the patient.**