Usal Cosmetic Surgery Center

Registration Information

REFERRED BY: _____ER_____DR._____

LLene por favor las líneas proporcionadas.

Patient Information

Last Name: _____ **First Name:** _____ **MI:**___ **DOB:**_____**SS#:**_____
Apellido: Nombre: InicialMediano: Nacimiento Seguro Social#

Address: _____**City:** _____ **State:** _____ **Zip:**_____
Dirección: Ciudad: Estado: Código Postal

Home Phone: _____ **Work Phone:** _____ **Cell:** _____
Telefono: Trabajo: Celular:

Age: _____ **Allergies:** _____ **Sex: M / F** **Height:** _____ **/Weight:** _____
Edad: Alergias: Sexo: Altura/Peso:

Pt Employer: _____ **Employer Tel:** _____ **Occupation:**_____
Empleador: Telefono: Ocupación:

Employer Complete Address: _____ **Supervisor:** _____
Dirección: Supervisor:

In Case of Emergency: _____ **Relation:** _____ **Phone:**_____
En Caso de emergencia: Relación: Telefono

Primary DR: _____ **Address:**_____**Tel:** _____**Fax:**_____
Médico Primario: Dirección: Telefono: Fax:

Primary Insurance (Guarantor) **** MUST FILL OUT ****

Insurance Co.: _____ **Policy#:** _____ **Group#:** _____
Compañía de seguro: Numero de póliza: Numero del grupo:

Insurance Claims Address: _____ **City:** _____**State:** _____ **Zip:** _____
Los Reclamos al seguro Dirigen Ciudad: Estado: Código Postal:

Subscriber (If not Pt.): _____ **SS# :**_____ **DOB:** _____ **Relation:**_____
El suscriptor si no paciente: Seguro Social# Nacimiento: Relación:

Subscriber Employer: _____ **Employer Tel:** _____ **Occupation:**_____
Empleador del suscriptor: Telefono: Ocupación:

Employer Address: _____**City:** _____ **State:**_____ **Zip:** _____
Dirección: iudad: Estado: Código Posta

Worker's Comp: _____ **No Fault:** _____
Compensación de trabajadores: Seguro de automóvil:

Adjuster: _____ **Tel:** _____ **DOA:** _____ **Claim#:** _____
Ajustador de reclamos: Telefono: Fecha de accidente: Numero de reclamo:

Secondary Insurance

Insurance Co.: _____ **Policy#:** _____ **Group#:** _____
Compañía de seguro: Numero de póliza: Numero del grupo:

Insurance Claims Address: _____ **City:** _____**State:** _____ **Zip:** _____
Los Reclamos al seguro Dirigen: Ciudad: Estado: Código Postal:

Subscriber (If not Pt.): _____ **SS#:**_____ **DOB:** _____ **Relation:**_____
El suscriptor si no paciente: Seguro Social: Nacimiento: Relación:

Subscriber Employer: _____ **Employer Tel:** _____ **Occupation:**_____
Empleador del suscriptor: Telefono: Ocupación:

Employer Address: _____**City:** _____ **State:**_____ **Zip:** _____
Dirección: Ciudad: Estado: Código Postal:

Authorization to Release Medical Information: I hereby authorized Usal Cosmetic Surgery Center to release any information acquired during the course of my examination and treatment as requested by my insurance carrier, any agent working with, or on behalf of my Insurance carrier, The Health Care Administration, Any hospital, or Physician, this office may refer me to.

Authorization to take Photographs: I hereby authorize Usal Cosmetic Surgery Center to take photographs for my medical records and submit these to my insurance Company or attorney if I am not identified by name, for medical research, education and publication.

Authorization to Pay Benefits to Physician: I irrevocably assign Usal Cosmetic Surgery Center to all my rights and benefits under any insurance contracts for payment For services rendered to me. I irrevocably direct that all such payments go directly to Usal Cosmetic Surgery Center. I irrevocably authorize all information regarding My benefits under my insurance policy relating to any claim by Usal Cosmetic Surgery Center to be releases to Usal Cosmetic Surgery Center.

I understand that any deductible, co-payment, and/or non-covered amounts are my responsibility to pay. I understand that if the insurance company pays me directly for the services provided by Usal Cosmetic Surgery Center, it is my responsibility to endorse the payment to Usal Cosmetic Surgery Center. I understand that if I do not pay those amounts, which are my responsibility to pay, I will also be responsible for any additional fees incurred during the collection process, including the collection agency fees.

I have received information regarding the licensure, relevant educational training and experience on person(s) responsible for delivery of care, treatment and services.

***X*_____*DATE:* _____**