

PATIENT REGISTRATION

EDWARD J LOVE, MD

Patient Name _____
Patient Address _____
City _____ State _____ Zip Code _____
Home # () _____ Work # () _____ Cell/Other # () _____
Email Address _____
Sex (M)(F) DOB _____ SSN# _____ Marital Status (M)(S)(W)(D)
Pharmacy Name/Phone Number _____

Referred by.. () doctor () patient () advertisement () other _____
Please Specify _____
Address/Phone Number if Physician _____
Patient's Employment () Employed () Retired () Other Occupation _____
Place of Employment _____

Primary Insurance Carrier _____
Name and DOB of Insured _____
Insured ID Number _____
Group Number _____
Copay/Coinsurance Amount _____
Effective Date _____

Secondary Insurance Carrier _____
Name and DOB of Insured _____
Insured ID Number _____
Group Number _____
Copay/Coinsurance Amount _____
Effective Date _____

Emergency Contact _____
Telephone Number(s) _____
Address _____
Relationship _____

Unless previous arrangements have been made, we ask that you pay your bill at the time of your visit. As a service to our patients, we will complete and file an insurance form so that reimbursement may be made in a timely manner. You will be responsible for any amount not covered by insurance (deductible, coinsurance, copay, etc). Please sign the insurance authorization and assignment form below. All cosmetic fees are requested to be paid at least one week prior to surgery unless other arrangements have been made.

INSURANCE AUTHORIZATION AND ASSIGNMENT

Name of policy holder _____ request that payment for authorized Medicare/other insurance company benefits be made to The Plastic Surgery Institute, Edward J Love, MD for any services furnished by that party who accepts assignment/physician. Regulations pertaining to Medicare assignment of benefits apply.

I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers any information needed for this or a related Medicare claim/other insurance company claim. I permit a copy of this authorization to be used in the place of the original, and request payment of medical insurance benefits to the party who accepts assignment. I understand it is mandatory to notify the health care provider of any other party who may be responsible for paying for my treatment. (Section 1128B of the Social Security Act and 31 USC 3801-3812 provides penalties for withholding this information.)

Date _____ Signature _____

Signature of Guarantor if Patient is a Minor _____