PLASTIC SURGERY
Wright State Physicians

Miami Valley Hospital
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Patient Registration Form

Name ______________________ Emergency Contact (closest relative not living with patient) ______________________
Address ______________________ Contact's Phone # ______________________
City ______________________ State ______________________ Zip Code ______________________
Sex ☐ M ☐ F **(First, last name of physician and specify M.D. or D.O. please)**
DOB ______________________ Referring Physician ______________________
SSN ______________________ Other involved M.D.'s ______________________
Home # ______________________ Family Doctor ______________________
Cell # ______________________ Today's appt with ______________________
Alt # ______________________ Pharmacy Name ______________________
E-mail ______________________ Pharmacy Phone # ______________________
How did you hear about our office? ☐ TV ☐ Radio ☐ Newspaper ☐ Magazine ☐ Friend
Marital Status ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Primary Insurance

Company ______________________ Policy Holder ______________________
Policy Holder Name ______________________ SSN ______________________
Employer ______________________ DOB ______________________
Relation of patient to insured ______________________ ☐ **Same as patient information listed above.**

Secondary Insurance

Company ______________________ Policy Holder ______________________
Policy Holder Name ______________________ SSN ______________________
Employer ______________________ DOB ______________________
Relation of patient to insured ______________________ ☐ **Same as patient information listed above.**

Responsible Party **Amounts not paid by insurance company will be billed to this person.**

Name ______________________ Employer ______________________
Address ______________________ Address ______________________
City, State, Zip Code ______________________ City, State, Zip Code ______________________
Birthdate ______________________ Phone # ______________________ Ext. __________
☐ **Same as patient information listed above.**

Comments and/or any special needs **(i.e. wheelchair, stretcher, interpreter, etc.):**

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Consent to treat and authorization for release of billing information

Please read completely and sign. Services may be withheld if not signed.
I recognize the need for health care and consent to services as ordered by the physician(s). I hereby authorize the release of any medical information necessary from Wright State Physicians for services described herein. Regardless of my insurance benefits, if any. I understand that I am financially responsible for the fees of services rendered.

I have read the above and understand my financial responsibilities.

______________________________ ______________________________
SIGNATURE OF PATIENT (Parent or Guardian if a Minor) Date Signed