

STATESBORO PLASTIC SURGERY – NEW PATIENT FORM

(912) 681-3330

Patient Information as of _____ (enter today's date)
(Please Print Legibly & Fill In or Correct All Fields)

Patient's Name _____
Last First Middle

Address _____
Street & Apt # City State Zip

Home Phone _____ Cell Phone _____ Other Phone _____

Can we contact you and/or leave a message at these numbers? No Yes E-mail _____
Can we send you confidential information to you? No Yes

Age _____ Birthdate ____ / ____ / ____ SS# ____ - ____ - ____ Sex Female Male
Marital Status Single Married to: _____ Other: _____

Patient's Employer _____ Occupation _____
 Yes No

Work Phone _____ Ext: _____ Is it okay to call you at work?

Address _____
Street & Suite # City State Zip

How did you hear about ? (Mark all that apply)
 TV News TV Ad Phone Book Magazine Newsletter Seminar Salon Web
 Friend/Relative: _____ Doctor: _____ Other: _____
If you were referred by a specific person, may we thank them? Yes No

Emergency Contact
(Not in your household) _____ Relationship to Patient _____
Home Phone _____ Work Phone _____ Other Phone _____
Address _____
Street & Apt # City State Zip

Primary Health Insurance Company _____
Policy Holder's Name _____ DOB _____ SS# _____

Secondary Health Insurance Company _____
Policy Holder's Name _____ DOB _____ SS# _____

I understand that office visit charges are payable on the day service is rendered. I authorize Dr. Bisseck to bill my insurance company. Regardless of insurance coverage, I am responsible for all bills being paid in a timely manner. I understand that my contract is between Dr. Bisseck and myself. I further understand that any portion of the bill that the insurance company or responsible party does not cover is my responsibility.
I hereby agree that if my bill has to be turned over to a third party collection agency for non payment, there will be a collection fee added to my bill. This is pursuant to Georgia Statutory Law "O.C.G.A.-13-1-11".

Signature _____ **Date** _____