

Patient #: _____

PATIENT REGISTRATION

Please print and complete all items

Today's Date: _____ Name: _____

Mailing Address: _____

Residential Address: _____

Home Telephone #: () _____ E-mail address: _____

Fax #: _____ Cell phone # / Pager #: _____

Out of state/country address (if applicable): _____

Gender: _____ Age: _____ Date of Birth: _____ Social Sec. # _____

Please tell us how you heard about Doctor Fernandez _____

May we send the above person (if applicable) a thank you note? Yes No

Occupation: _____ Employer's Name and Telephone #: _____

Married Single Wid. Div. Sep. Spouse's Name (if applicable): _____

PERSON TO NOTIFY IN CASE OF EMERGENCY

Name: _____ Relationship: _____

Address: _____ Telephone #: () _____

PERSON RESPONSIBLE FOR PAYMENT

Name: _____ Relationship: _____

Address: _____ Telephone #: () _____

Employer's Name and Telephone #: _____ Occupation: _____

INSURANCE INFORMATION (if applicable)

Primary Carrier

Name of Company: _____

Claims Address: _____

Identification #: _____

Group/Policy #: _____

Secondary Carrier

Name of Company: _____

Claims Address: _____

Identification #: _____

Group/Policy #: _____

GENERAL PERMIT FOR PROFESSIONAL SERVICES

I hereby request, consent and authorize Enrique J. Fernandez, M. D. and Bradenton Plastic Surgery, P. A., to perform professional services which may include consultants, anesthesiologists, laboratory personnel, and others as may be necessary or advisable by my physician. I agreed to assume full financial responsibility for any and all charges including those of the surgeon(s), hospital, laboratory, and other charges as may be necessary in connection with my care and treatment. I consent to be photographed before, during and after treatment. Any such photographs may be used for scientific and educational purposes, including but not limited to, scientific publications, medical journals and seminars provided that I am not identified by name. I understand that although good results are expected, they cannot be and are not guaranteed, nor is there any guarantee against untoward results.

Print Patient Name

(X) _____

Patient/legal Guardian

Date

ALL PATIENTS:

I authorize the release of any and all medical information necessary to process insurance claims. I further authorize payment of medical benefits to, if an insurance claim is filed. I understand Dr. Enrique J. Fernandez does not participate in the _____ Program and I will be subject to reimbursement at out-of-network benefit levels and will be responsible for any amount not allowed. I understand any question I may have regarding my benefit coverage should be directed to my insurance company. I request and consent to the use of E-mail by Bradenton Plastic Surgery, PA as deemed necessary to communicate with me.

(X) _____

Patient/legal Guardian

Date

MEDICARE PATIENTS:

LIFETIME MEDICARE B SIGNATURE AUTHORIZATION: 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, or to other billing agents of _____ any and all information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits, either to myself or to the party who accepts assignment.

(X) _____

Patient/legal Guardian

Date