NORTH CAROLINA PLASTIC SURGERY CENTER, P.A.
PATIENT INFORMATION SHEET

(Print Below!)

PATIENT'S #				E-Mail Address:	
PATIENT'S NAME (Last)	(First)	(Middle)		S.S. #	
STREET ADDRESS	CITY			STATE	ZIP CODE
BIRTH DATE	AGE	SEX M_ F_	MARITAL STATUS M_ S_ D_ W_ SEP_	HOME PHONE # ( )	
PATIENT'S EMPLOYER				MOBILE PHONE #	
STREET ADDRESS	CITY AND STATE		ZIP CODE	BUSINESS PHONE # ( )	
SPOUSE'S NAME	S.S.#	SPOUSE'S EMPLOYER		BUSINESS PHONE # ( )	
REFERRAL SOURCE	STREET ADDRESS				
CITY AND STATE			ZIP CODE	PHONE # ( )	
WHICH DOCTOR ARE YOU SEEING TODAY?	HAVE YOU BEEN SEEN IN OUR OFFICE IN THE PAST?	IF SO, WHEN?	WHICH DOCTOR DID YOU SEE?		
EMERGENCY CONTACT PERSON	RELATIONSHIP TO PATIENT	PHONE # ( )			
NATURE OF INJURY	Date				
WERE YOU INJURED AT WORK YES NO	Date				

PAYMENT IS EXPECTED AT TIME SERVICES ARE RENDERED

PERSON RESPONSIBLE FOR PAYMENT	STREET ADDRESS	CITY AND STATE	ZIP CODE	
BIRTH DATE / S.S. #	HOME PHONE # ( )	NAME OF EMPLOYER	BUSINESS PHONE # ( )	
NAME OF PRIMARY INSURANCE COMPANY	STREET ADDRESS / P.O. BOX	CITY AND STATE	ZIP CODE	
PHONE # ( )	INSURED'S NAME	S.S. #	BIRTH DATE	POLICY/GROUP #
NAME OF SECONDARY INSURANCE COMPANY	STREET ADDRESS / P.O. BOX	CITY AND STATE	ZIP CODE	
PHONE # ( )	INSURED'S NAME	S.S. #	BIRTH DATE	POLICY/GROUP #

I authorize North Carolina Plastic Surgery Center, P.A. to release any information to my insurance company or physicians acquired in the course of my examination or treatment. I also authorize photographs to be taken and released to my insurance company as acquired in the course of my examination or treatment. I understand that I am financially responsible for charges not covered by this authorization and guarantee payment of this account. A monthly service charge of 1½% (18% annual percentage rate) will be charged on accounts not paid within 90 days. **I AUTHORIZE PAYMENT DIRECTLY TO NORTH CAROLINA PLASTIC SURGERY CENTER, P.A.**

Date _____ Signature of Patient _____

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