Rao Plastic & Hand Surgery

PATIENT REGISTRATION

IN ORDER TO SERVE YOU PROPERLY, WE NEED THE FOLLOWING INFORMATION.
PLEASE PRINT ALL INFORMATION WILL BE CONFIDENTIAL.

Patient Name:_____ Birth Date:_____ Age:_____
Last First MI Nickname

Address: _____
Street City State Zip Code

Primary Phone #:_____ Cell Phone #:_____ Social Security #: _____

E-mail address:_____ Sex: ☐ Male ☐ Female

Driver License #_____ State_____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed Spouse Name: _____

Race:_____ Ethnicity: ☐ Hispanic ☐ Non-Hispanic Preferred Language: _____

Referring Doctor: _____ Family Physician: _____

Whom may we thank for referring you? _____

Employer:_____ Occupation:_____ Employer Phone #: _____

Is this visit due to an injury on the job? Yes No Date of Injury: _____

You must provide billing information from your employer.

Person responsible for bill, if other than the patient:_____ Phone #: _____

Responsible person's Employer:_____ Responsible person's Social Security #: _____

We will be prescribing medications electronically and need your permission to access your prescribed medications to avoid drug interactions and duplication. Your signature below will act as permission. Please provide your preferred pharmacy information:

Pharmacy Name/Cross Streets OR Address/Phone #:

_____

_____

In case of emergency, notify: _____ Phone #: _____ Relationship: _____

Do you have a Living Will? _____ (Submit copy to front desk)

If needed, I consent to the transfusion of any Blood/Blood products Y N

I attest that the information provided above is true and accurate. I acknowledge that I have read, signed and will abide by Rao Plastic & Hand Surgery, "Patient Payment and Financial Policies".

Patient's Signature:_____ Date: _____
(or Parent/Guardian if patient is a minor)