

ARTHUR W PERRY, MD, FACS PLASTIC SURGERY CENTER

Patient Registration

Name of Patient _____ **Date** _____
First Name Initial Last Name

Birthdate _____ Age _____ Marital Status- S __ M __ D __ W __

Address _____
Street City State Zip Code

Phone (cell) _____ (home) _____
Area Code Area Code

Email address _____ Occupation _____

Employer _____

Business Address _____
Street City State Zip Code

Name of "Significant Other" _____ Phone (cell) _____

Referred by _____

Insurance Information

Insurance Company and Address _____
Subscriber Name and Number _____ *Group Number* _____

Secondary Insurance Company _____
Subscriber Name and Number _____ *Group Number* _____

Assignment of Benefits I authorize payment of medical benefits to Dr. Perry or myself for professional services rendered. Signed _____ Date _____ (Subscriber)	Release of Information I authorize the release of any medical information necessary to process this claim. Signed _____ Date _____ (Patient or Parent)
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Method of Payment: *Cash* _____ *Check* _____ *Credit Card* _____

I accept responsibility for payment of services rendered. *I understand that consultations may be recorded for medical record keeping purposes.*

We ask patients to download the Symplast app for communication with this office. Communications within the Symplast app (including video and texting) are HIPAA compliant and assure your privacy but communications outside of the app potentially expose you to privacy breaches. Should you choose to send photographs or communicate via FaceTime, you acknowledge that Dr. Perry is not responsible for potential privacy breaches.

Your signature below acknowledges the office policies outlined in this Registration Form.

Signature _____ **Date** _____ 7/26