Cary Plastic Surgery Center
Patient Registration

Date: _____ Patient #: _____

Name	Sex ☐ Male ☐ Female	Date of Birth	Age	Marital Status ☐ Single ☐ Widowed ☐ Married ☐ Separated ☐ Divorced
Address (if temporary, write permanent address below)	City, State, Zip Code			Telephone

REFERRED BY ☐ Friend _____ ☐ Doctor _____ ☐ Yellow Pages
☐ Patient _____ ☐ ER/Hospital _____ ☐ Self/Other

Patient Employer (indicate if student)	Occupation	Business Telephone
Employer's Address	City, State, Zip Code	
Spouse/Parent/Guardian/Name	Employer	Business Telephone
Address (if different from above)	City, State, Zip Code	Telephone (if different)
Person to notify in case of emergency	Home Telephone	Business Telephone
Social Security Number	Reason for today's visit	

INSURANCE POLICY NO. 1	INSURANCE POLICY NO. 2	MEDICARE
Insured's Name	Insured's Name	Insured's Name
Insured's I.D. Number (include any letters)	Insured's I.D. Number (include any letters)	Medicare No. (include any letters)
Insured's Group Number (or group name)	Insured's Group Number (or group name)	
Insurance Company Name	Insurance Company Name	
Address for mailing claims	Address for mailing claims	
City State Zip	City State Zip	

PERSON RESPONSIBLE FOR PAYMENT, IF NOT PATIENT	Relationship to Patient	Telephone Home: _____ Work: _____
Does your Insurance Company require authorization to see a specialist? ☐ No ☐ Yes	Surgery ☐ No ☐ Yes	
Address of responsible person (if different from patient)	City, State, Zip Code	

Accident ☐ No ☐ Yes Date _____ Do you have an attorney? ☐ No ☐ Yes Name _____
Telephone _____

DRUG ALLERGIES	Alcohol ☐ Never ☐ Occasionally ☐ Rarely ☐ Frequently	Smoking ☐ No ☐ Yes Packs/day Years
Present Medications		
Previous Operations		

ASSIGNMENT OF BENEFITS

I authorize my insurance company, attorney, or other party to Cary Plastic Surgery any medical expenses related to my care. I further authorie Donald P. Hanna, M.D. to furnish any information requiring insurance claims. I accept responsibility for any medical expenses incurred, regardless of insurance coverage. A reproduction of this document shall be valid.

_____ Date _____ _____ Date _____
PATIENT SIGNATURE Parent or Guardian Signature if Minor Patient

PHOTOGRAPHIC ILLUSTRATIONS

I hereby give permission to Donald P. Hanna, M.D. to take any photographic or other illustrations of the above-named patient deemed advisable for diagnostic purposes and/or to enhance the medical record. I further authorize the use of such illustration for teaching purposes or to illustrate scientific papers or lectures without inspection or approval of the finished product or the specific use to which it may be applied.

_____ Date _____ _____
PATIENT SIGNATURE Witness