

## Burt and Will Plastic Surgery and Laser Centre Registration

Date: \_\_\_\_\_

PATIENT NAME _____ STREET 1 _____ STREET 2 _____ CITY _____ STATE & ZIP _____ HOME PHONE _____ CELL PHONE _____ WORK PHONE _____ E-MAIL ADDRESS _____ DATE OF BIRTH _____ MARITAL STATUS _____ SOCIAL SECURITY NUMBER _____ RACE _____ <small>(White, Black, Hispanic, Asian, Indian, Native American, Eskimo, Other)</small>	PATIENT OCCUPATION _____ PATIENT EMPLOYER _____ STREET 1 _____ STREET 2 _____ CITY _____ STATE & ZIP _____ EMPLOYERS PHONE _____  <b>PHARMACY NAME</b> _____ CITY AND PHONE _____ <b>PATIENT PRIMARY CARE DOCTOR</b> NAME _____ ADDRESS _____ CITY, STATE, ZIP _____
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### BILLING/ACCOUNT INFORMATION:

<b>PRIMARY CARDHOLDER</b> NAME _____ STREET 1 _____ STREET 2 _____ CITY _____ STATE & ZIP _____ HOME PHONE _____ CELL PHONE _____ WORK PHONE _____ DATE OF BIRTH _____ MARITAL STATUS _____ SOCIAL SECURITY NUMBER _____	<b>INSURANCE INFORMATION</b> PRIMARY INSURANCE COMPANY _____ PRIMARY INSURANCE POLICY HOLDER/SUBSCRIBER NAME/DOB _____ WHAT COMPANY/ORGANIZATION/EMPLOYER PROVIDES THIS INSURANCE COVERAGE? _____ WHAT IS THE EMPLOYMENT STATUS OF THE POLICY HOLDER/SUBSCRIBER? <small>(FULLTIME PART TIME, STUDENT, PART TIME STUDENT, RETIRED, UNEMPLOYED, SELF EMPLOYED, UNKNOWN)</small>
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### CARDHOLDER'S EMPLOYER:

NAME _____ STREET1 _____ STREET2 _____ CITY _____ STATE & ZIP _____ HOME PHONE _____ CELL PHONE _____ OCCUPATION _____	<b>SECONDARY INSURANCE COMPANY</b> SECONDARY INSURANCE COMPANY _____ SECONDARY INSURANCE POLICY HOLDER/SUBSCRIBER NAME _____ WHAT COMPANY/ORGANIZATION/EMPLOYER PROVIDES THIS INSURANCE COVERAGE? _____ WHAT IS THE EMPLOYMENT STATUS OF THE POLICY HOLDER/SUBSCRIBER? <small>(FULLTIME PART TIME, STUDENT, PART TIME STUDENT, RETIRED, UNEMPLOYED, SELF EMPLOYED, UNKNOWN)</small>
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### FOR NEW PATIENTS

How were you referred to our clinic or what is your reason for choosing our clinic? (Please circle one)		
Newspaper Publication? _____	Advertisement Insurance	Community Event Yellow Pages
Office Hours	ER Visit	Website
Yellow Pages	Physician Referral	Other
Internet	Family/Friend : Name _____	
	May we correspond with them: Yes No	

**You must provide all insurance cards at the time of registration.**

**Please fill out all pages in this new patient packet.**

**Co-payments are due at each visit.**

**All payments are to be made payable to:  
Burt & Will Plastic Surgery, SC.**

*Thank you for choosing Burt and Will Plastic Surgery and Laser Centre*