MILE HIGH plastic surgery

PATIENT REGISTRATION

CO-PAY_____

Patient Last Name_____ First Name_____ Middle Initial____

SS#_____ DOB_____ Sex M F

Address_____Apt#_____ City_____ State____Zip_____

Home Phone_____ Work Phone_____ Cell Phone_____

E-mail _____ Preferred number to call_____

Preferred Contact Method: Phone _____ Text_____ Email_____

Emergency Contact:_____ Contact Phone Number_____

Employer Name_____

Address_____ City_____State____ Zip_____ Phone_____

Primary Care Physician _____

Referring Physician_____

Is this appointment work or auto related?

If yes, Claim#_____ Ins. Co._____

Phone Number_____ Contact Person's Name_____

STAPLETON | 2975 Roslyn Street, Suite 140 Denver, CO 80238
THORNTON | 9141 Grant Street, Suite 125, Thornton, CO 80229
LAKEWOOD | 11700 West 2nd Place, Medical Plaza 2, Suite 210 Lakewood, CO 80228

ph 303.909.6977 fx 303.954.4779 milehigh-plasticsurgery.com

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Primary Insurance:

Insurance Name_____ Referral Needed Yes No

Policy#_____Group#_____Phone#_____

Name of Insured_____ Relationship_____

DOB_____ SS#_____

Address_____Apt# ____City_____ State_____ Zip_____

Secondary Insurance:

InsuranceName_____ Referral Needed Yes No

Policy#_____Group#_____Phone#_____

Name of Insured_____Relationship _____

DOB_____ SS#_____

Address_____ Apt#_____ City_____ State____ Zip_____

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Authorization and Release

I hereby authorized Nathan Roesner, D.O. and providers of Mile High Plastic Surgery to treat the patient identified above. I acknowledge that I am responsible to pay all charges for all treatments administered by the physician to the patient. I understand that insurance may not pay for all charges and I understand that I am obligated to pay for all charges not paid by insurance. I also agree to pay reasonable attorney fees if my account is turned over to an attorney or collection agency.

Signature of Patient / Authorized Person_____ Date_____

Assignment and Release: I hereby authorize my insurance benefits to be paid directly to the physician and I am financially responsible for non-covered services . I also authorize the physician to release any information required in the processing of this claim and all future claims.

Signature of Patient / Authorized Person_____ Date_____

Would you like to receive Emails for Special Events or Discounts? Yes No

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PATIENT HIPAA QUESTIONAIRE

Please list the family members or significant others, if any whom we may inform about your medical condition: ONLY IN AN EMERGENCY:

Name _____ Phone_____

Name _____ Phone_____

Please print the address of where you would like your billing statements and /or correspondence from our office to be sent if other than your home address.

_____

Please indicate if you want all correspondence from our office sent in a sealed envelope marked "CONFIDENTIAL": YES _____ NO_____

Please print the telephone number where you want to receive calls about your appointments, lab and x-ray results, or other health care information if other than your home phone number:

( )_____

I am fully aware that a cell phone is not a secure and private line.

I am fully aware my health information can be transmitted by facsimile (fax, mail or the internet).

Can confidential messages (i.e., appointment reminders) be left on your home answering machine or voicemail? YES_____ NO_____

PATIENT/GUARDIAN NAME:_____

PATIENT/GUARDIAN SIGNATURE:_____ DATE:_____

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