Patient Information

Social Security #: ______________________

Last Name: ________________________ First: ____________________ MI: ______

Street Address: _________________________________ Apartment #: ________

City: _____________________ State: _________ Zip Code: ___________

Home Phone: (   )____________________

Birth Date: ___________ Age: ______ Sex: ___ Race: ________________

Marital Status (circle one): **Single Married Divorced Widowed Separated**

Employment (circle one): **Full Part Retired None** Student: **Full Part**

Relationship to Insured (circle one): **Self Spouse Child Other**

Employer Name: ________________________ Business Phone: _______________

Address: _______________________ City: __________ State: ____ Zip: ________

Referring Doctor: _______________ Reason for Today's Visit: _________________

Accident? **yes no** If Yes, Date of Accident: _______ Nature of Accident: ________________

Do we have permission to:

Leave a message on your home answering machine? **yes no**

Leave a message at your place of employment? **yes no**

Talk with a family member about your condition? **yes no**

If patient is a minor, please fill out the following:

Responsible Parent/Guardian: _______________________ SS #: ________________

Address: _________________________________ Birth Date: ________________

Employer: ____________________________________ Phone: _________________

Wilmington Health
Plastic and Reconstructive Surgery
2421 Silver Stream Lane
Wilmington, NC 28401

Phone: 910.762.1234
Fax: 910.762.1232

wilmingtonhealth.com

Insurance Information

Primary Policy

Name: ______________________________________
Policy #: ____________________________________
Group #: ____________________________________
Insured's Name: ______________________________
Insured's SS #:_______________________________
Insured's Date of Birth: _______________________
Insured's Employer: ___________________________

Secondary Policy

Name: _____________________________________
Policy #: ___________________________________
Group #: ___________________________________
Insured's Name: _____________________________
Insured's SS #: ______________________________
Insured's Date of Birth: ______________________
Insured's Employer: __________________________

Consent for Treatment and Release of Medical Information:

I authorize treatment and/or services to myself or minor child at Wilmington Health Plastic and Reconstructive Surgery. I authorize the release of my medical records to my primary care, and/or referring, and/or consulting physician as needed, and as necessary to process insurance claims and prescriptions. I also authorize payment of medical benefits to Wilmington Health Plastic and Reconstructive Surgery.

Signed: _________________________________ Date:_________________________
Patient or Responsible Party

Payment Agreement:

I agree to pay my deductibles, co-payments, and payments at the time services are rendered. We accept cash, checks, and Visa/MasterCard/Discover.

Signed: _____________________________ Date: _________________________
Patient or Responsible Party

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